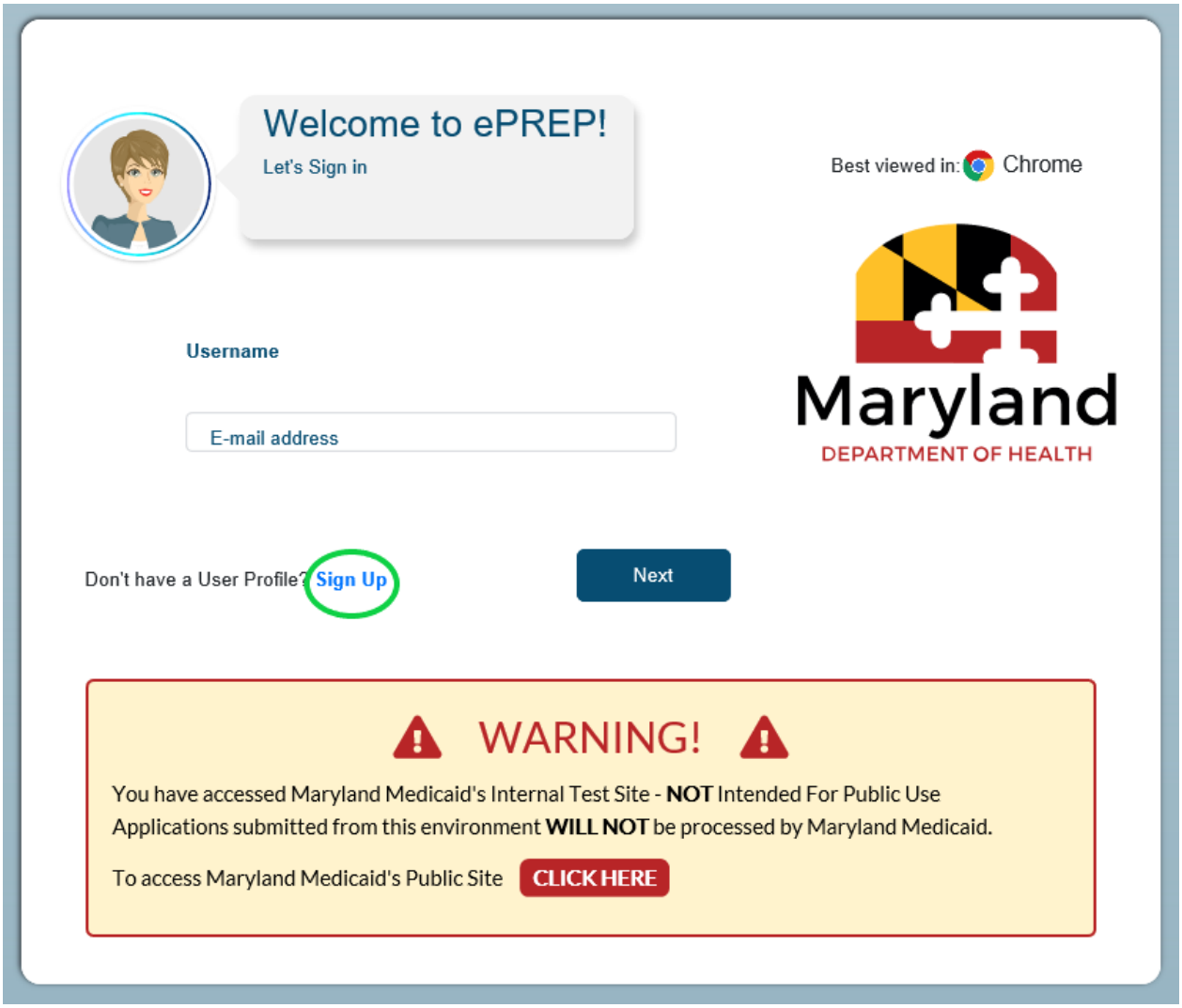
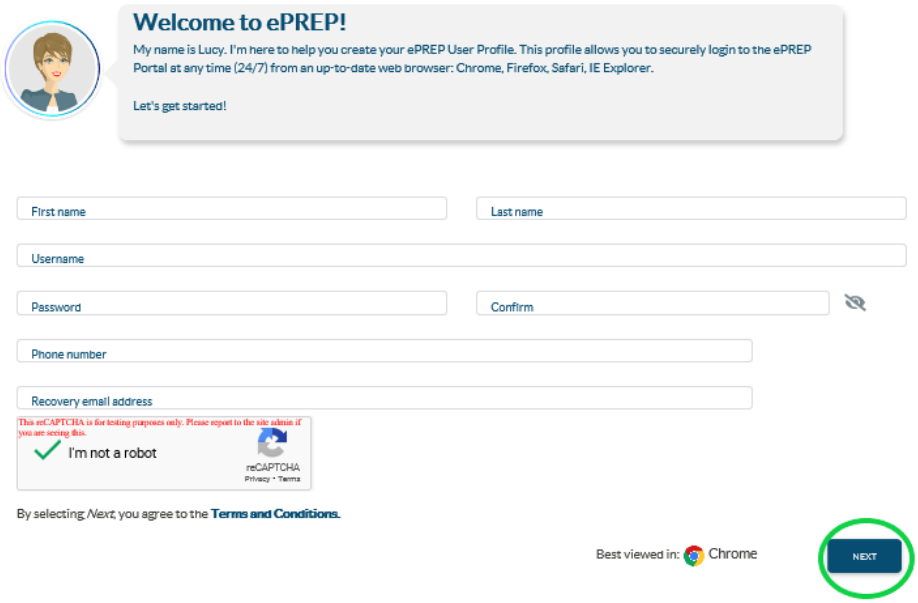
Welcome to the e PREP provider portal page!

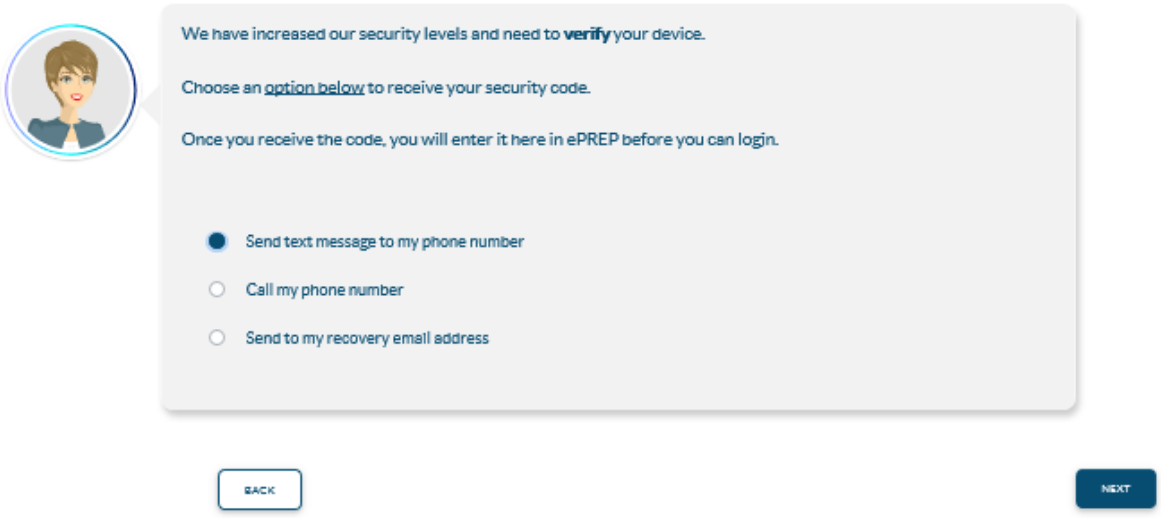
1. New providers/ groups enrolling with Maryland Medicaid for the first time will need to create a user profile. In order to begin this process, please click the “Sign Up” hyperlink shown below:



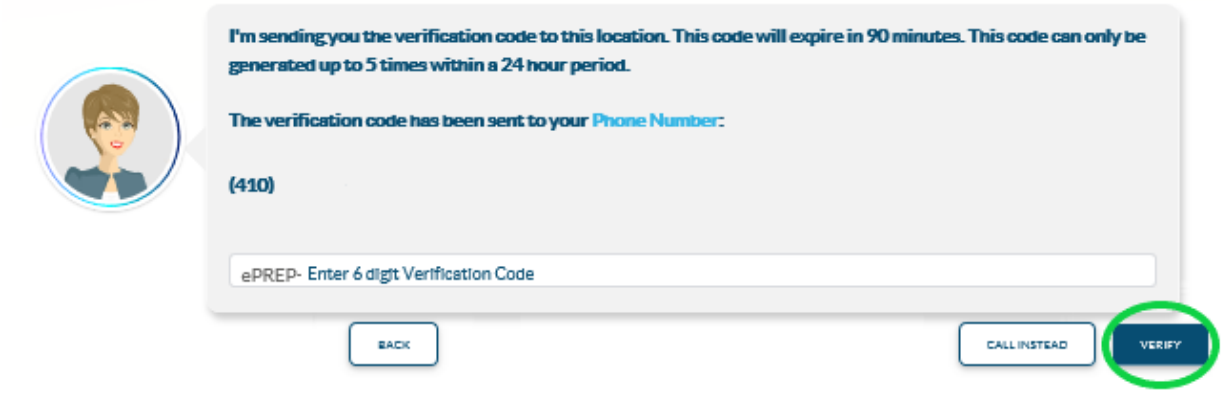
2. On this page, you will enter your personal information (first and last name), create a username, password and fill in all corresponding information followed by selecting the “Next” button when completed.

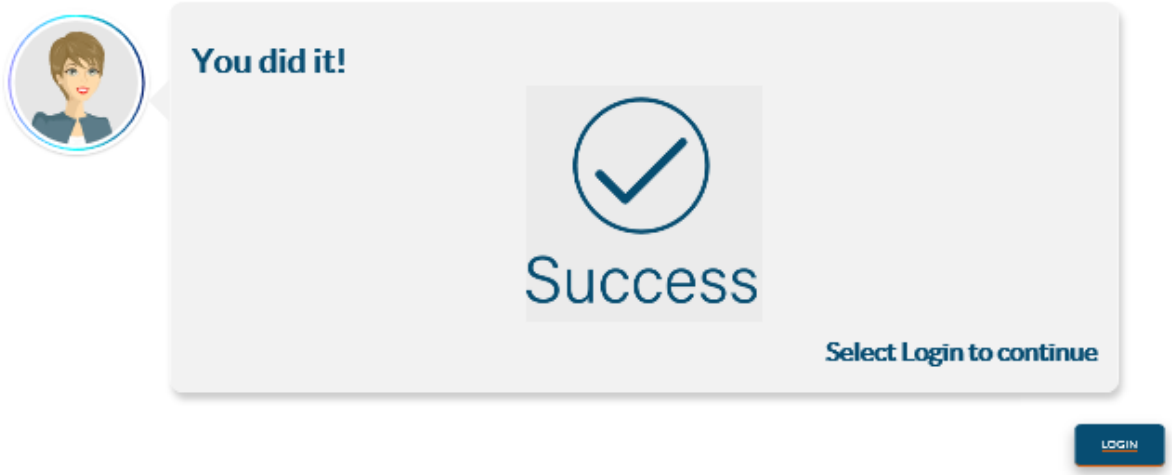


3. In an attempt to increase security measures within the portal, please determine how you would like to receive your authentication code - once you have made your selection, please click 'Next".

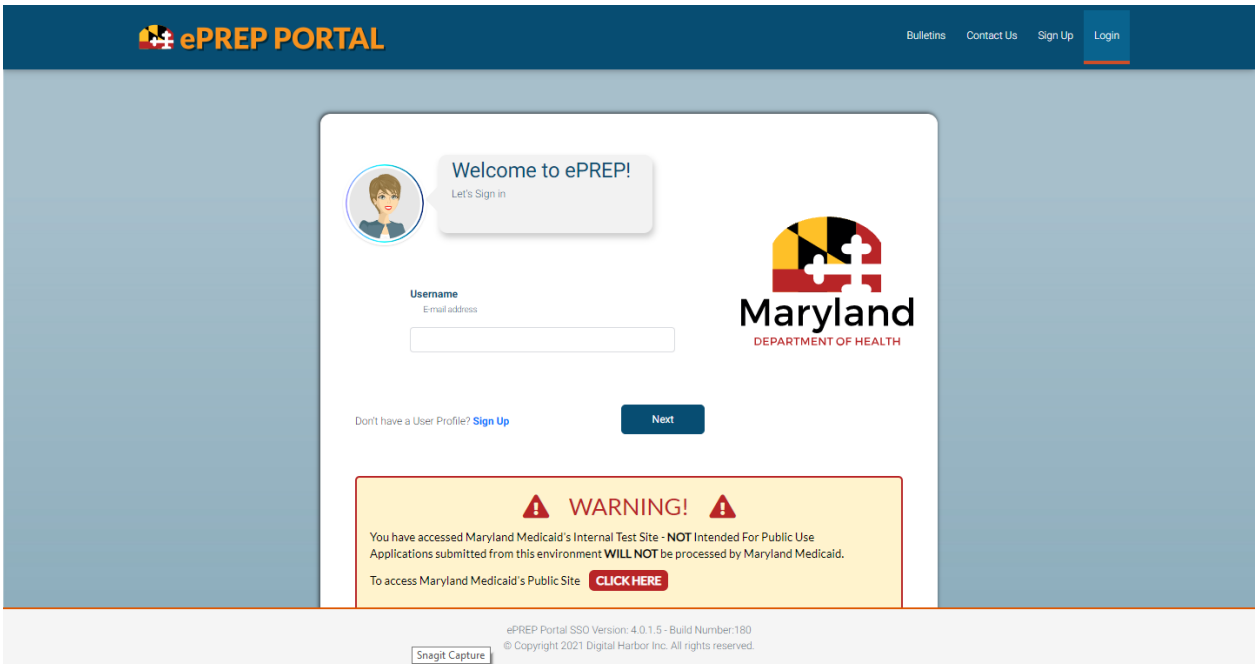


4. Please enter your 6 digit authentication code and click "Verify".

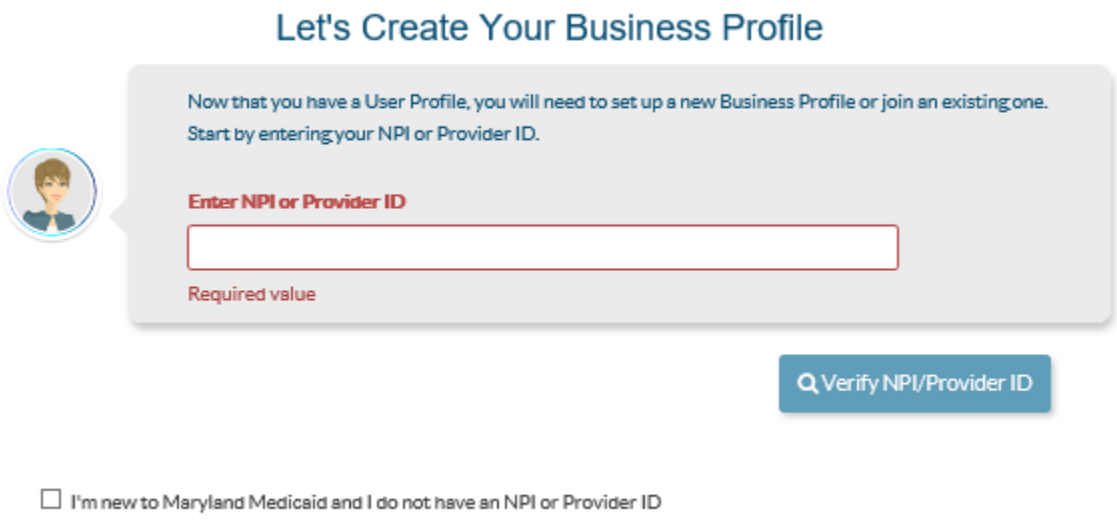




5. Once you have successfully entered and verified your security code, users will need to login for the first time with your username (email address) and password. Both of which were entered and created in the steps above.



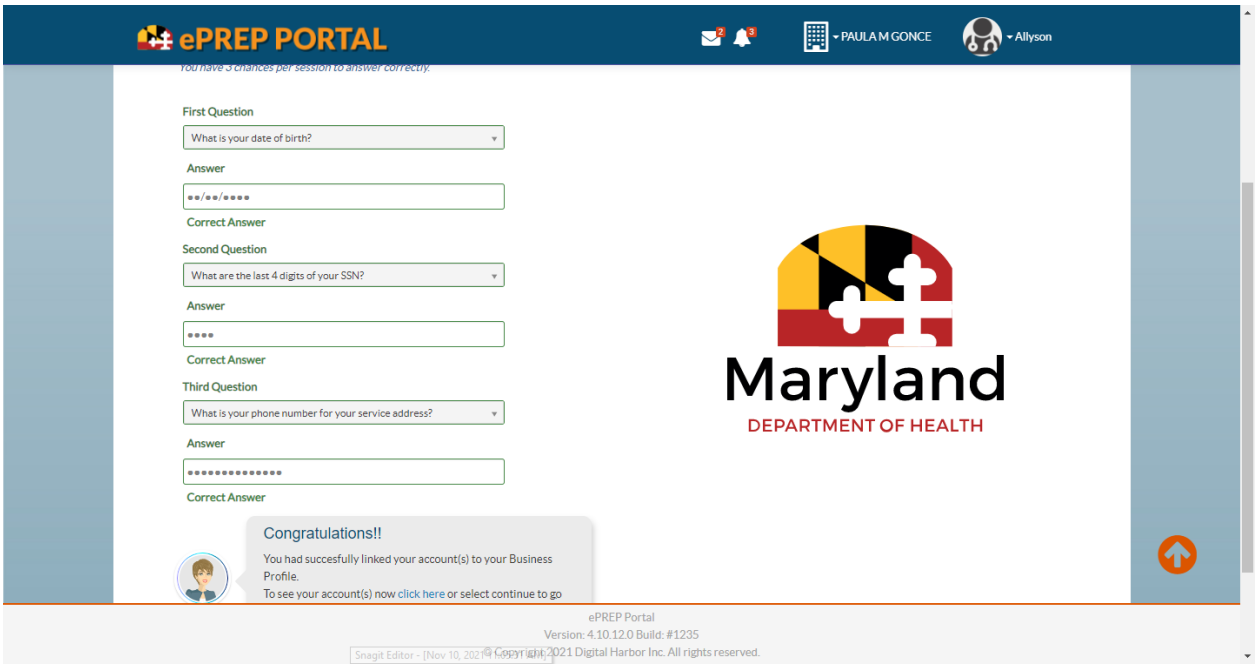
6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must first enter and verify your NPI number.



7. Once you have entered and verified your NPI, the provider ID box will turn green and you will be able to enter the provider / group name you are attempting to enroll.

This is the name that will be listed on your provider business profile.

8. Security questions portion: please select and correctly answer three corresponding security questions as they pertain to you. Once you have completed this portion, you will be able to continue moving forward through the business profile creation process by selecting "Next".



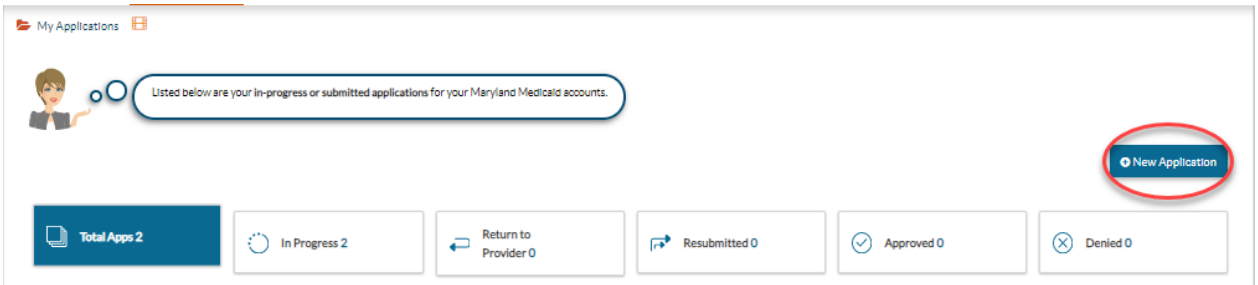
****It's important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process****

9. Once your business profile has been created, you will be taken to the e PREP home page

shown below:

10. From here, please click the “My Applications” tab / or building with the “My Applications” heading attached shown above.

11. Once you have successfully entered the “My Applications” tab, you will need to create a new application in order to enroll your provider type with Maryland Medicaid. **Circled in the screenshot below.**

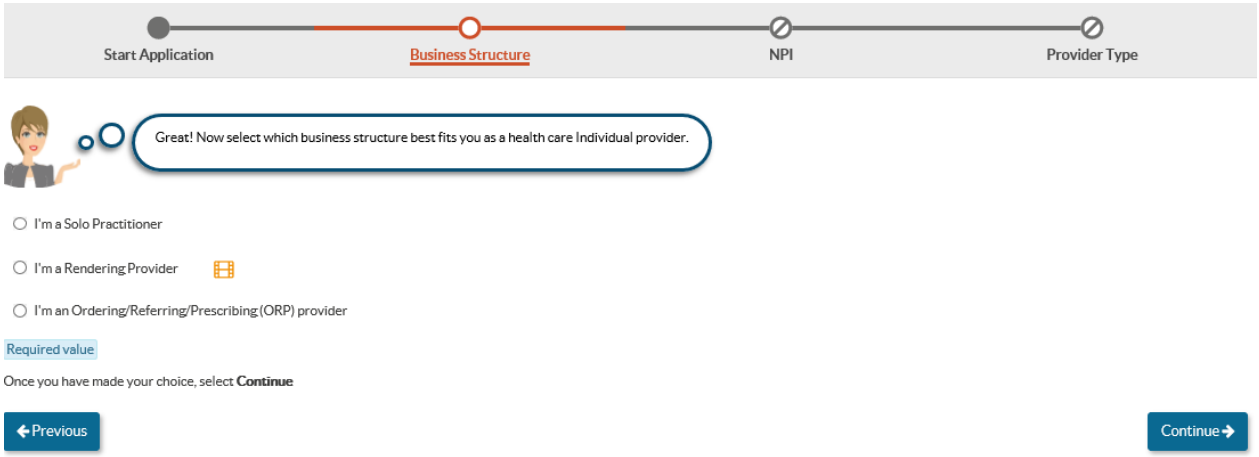


12. Application generation: one you have clicked the “New Application” tab, the following selection will need to take place in order to generate your enrollment application.

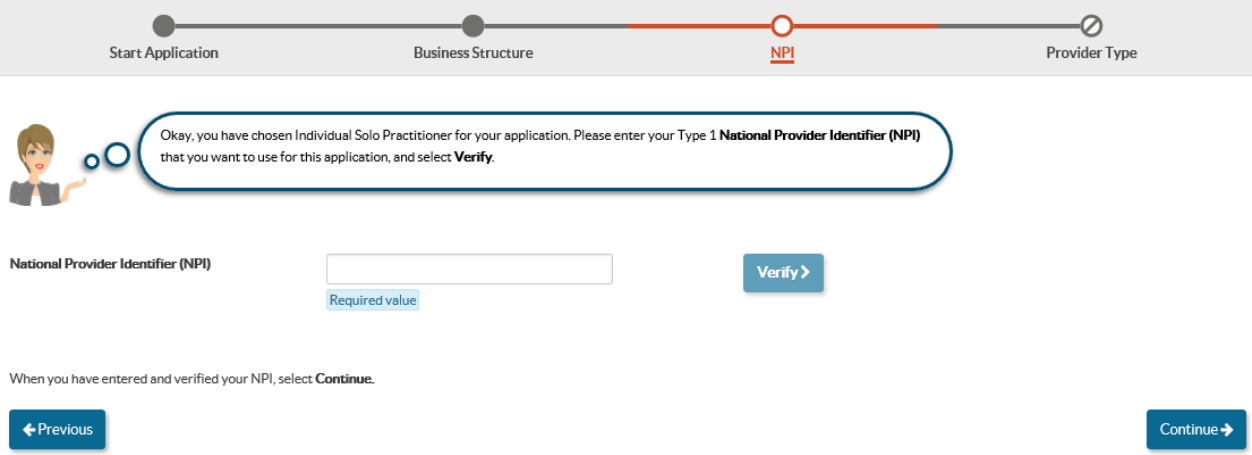
13. **Application Generation Selection**: please make the selections listed below:

- I'm new to Maryland Medicaid, and I want to create a new application
- I'm an Individual health care practitioner

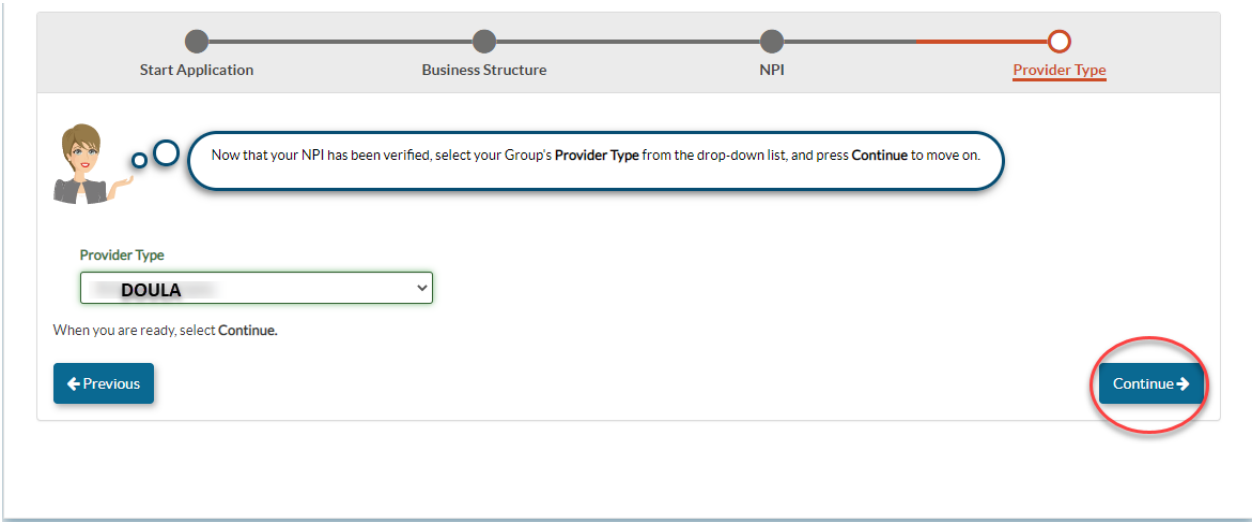
- Please select the Solo Practitioner or Rendering provider option based on your pay-to status. Once selected, please select continue.



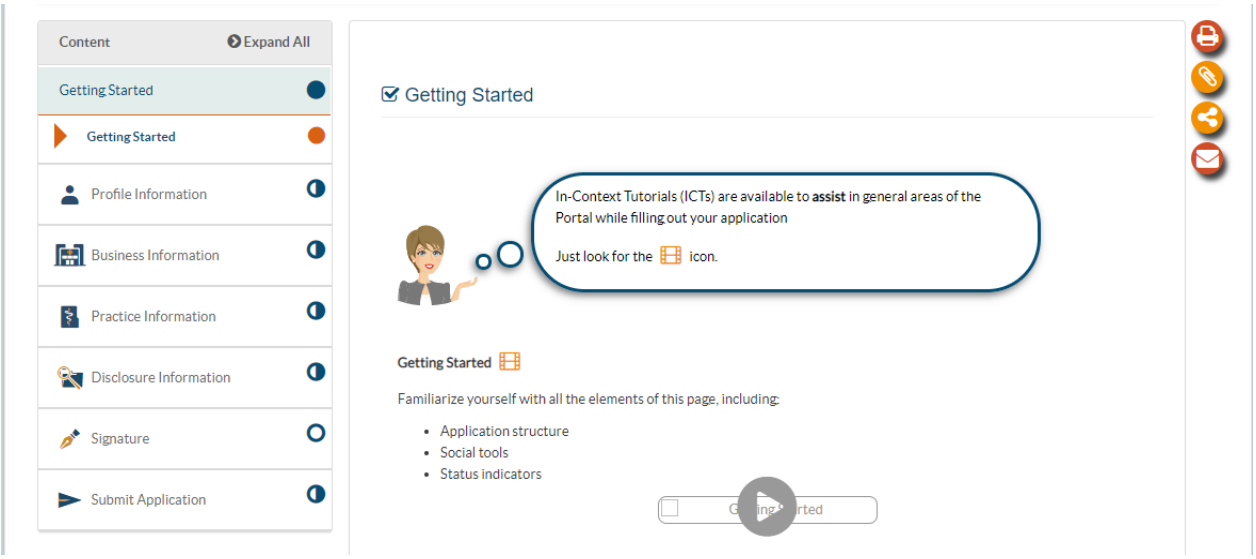
- Once you have entered your NPI, please click the “verify” option. Once the NPI has been verified, the NPI box will turn green and you will be able to successfully continue through the application generation process.



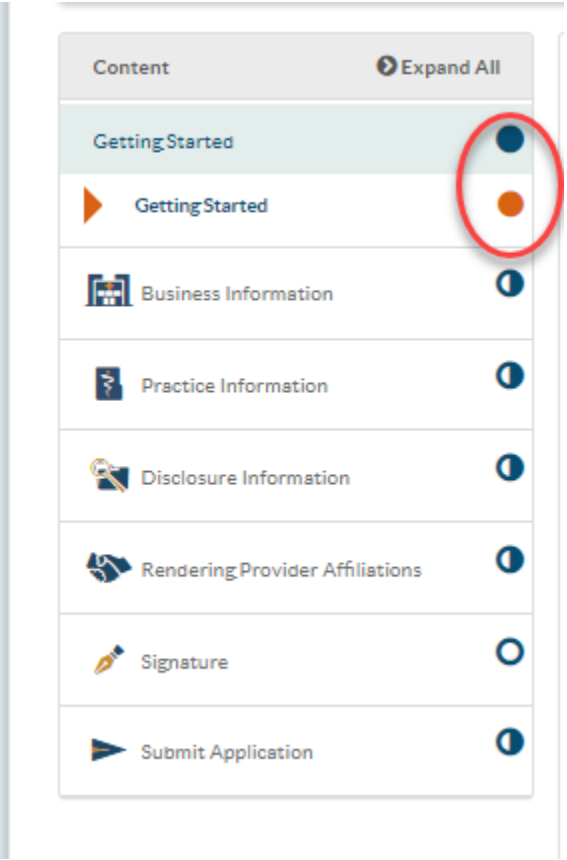
- **Provider type** - in the drop down box menu, please select the provider type **Doula** and click continue.



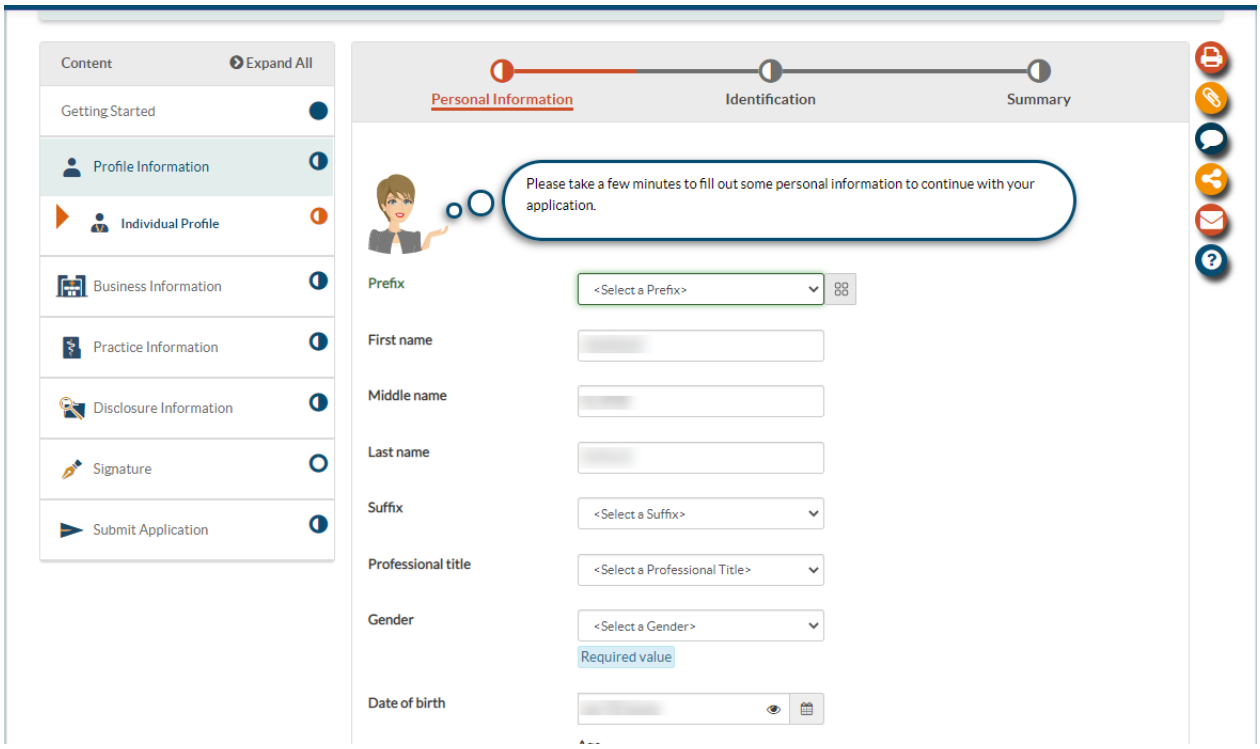
14. Successful Application Generation - Once you have generated the application, you will be able to complete each required section from start to submission.



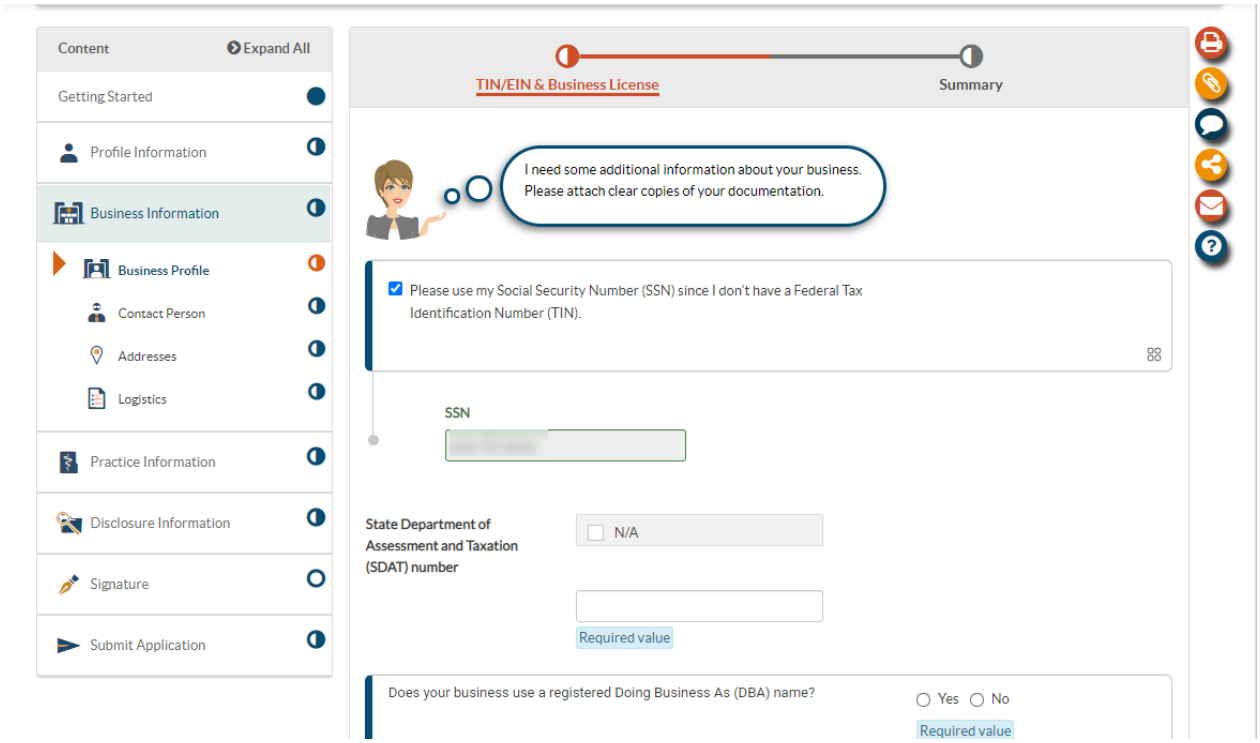
15. As you navigate the application, this side bar will indicate your progress. A fully shaded circle denotes a finished section, while a half shaded circle signifies an incomplete section. Example shown below:



16. **Profile Information**: Please enter all provider information into the corresponding data fields within this section.

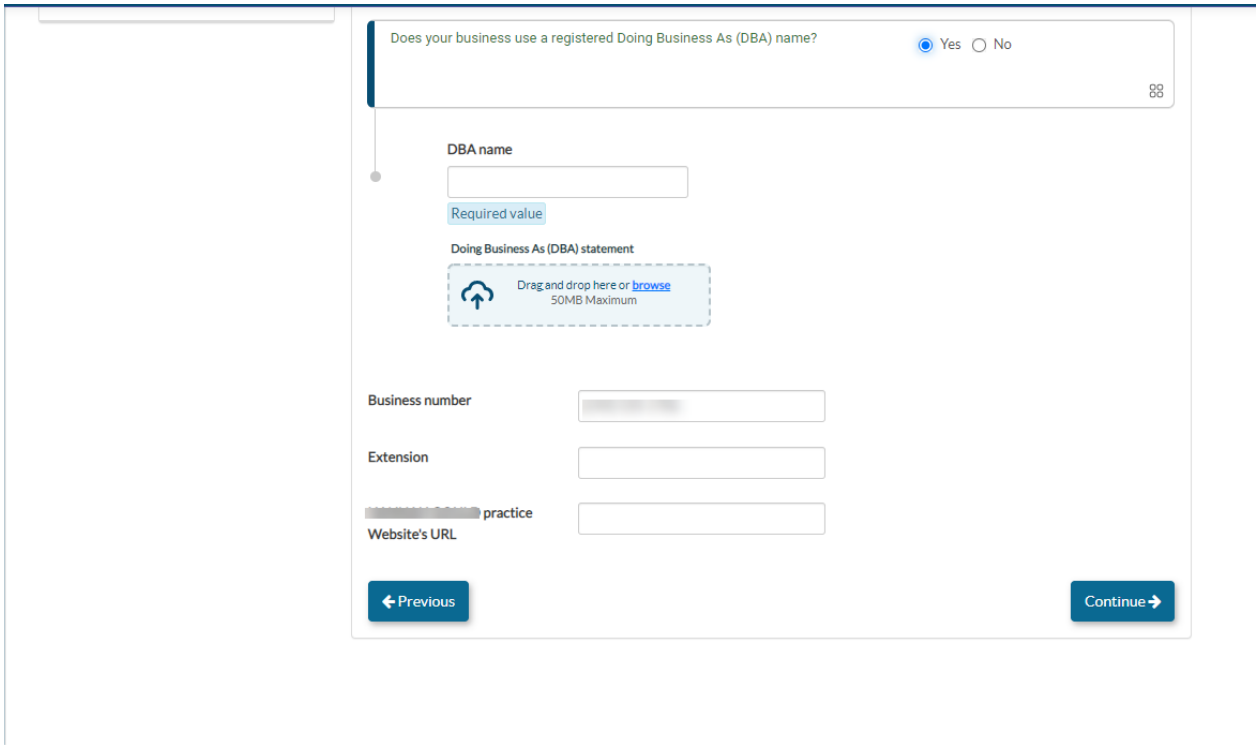


17. **Business Information:**

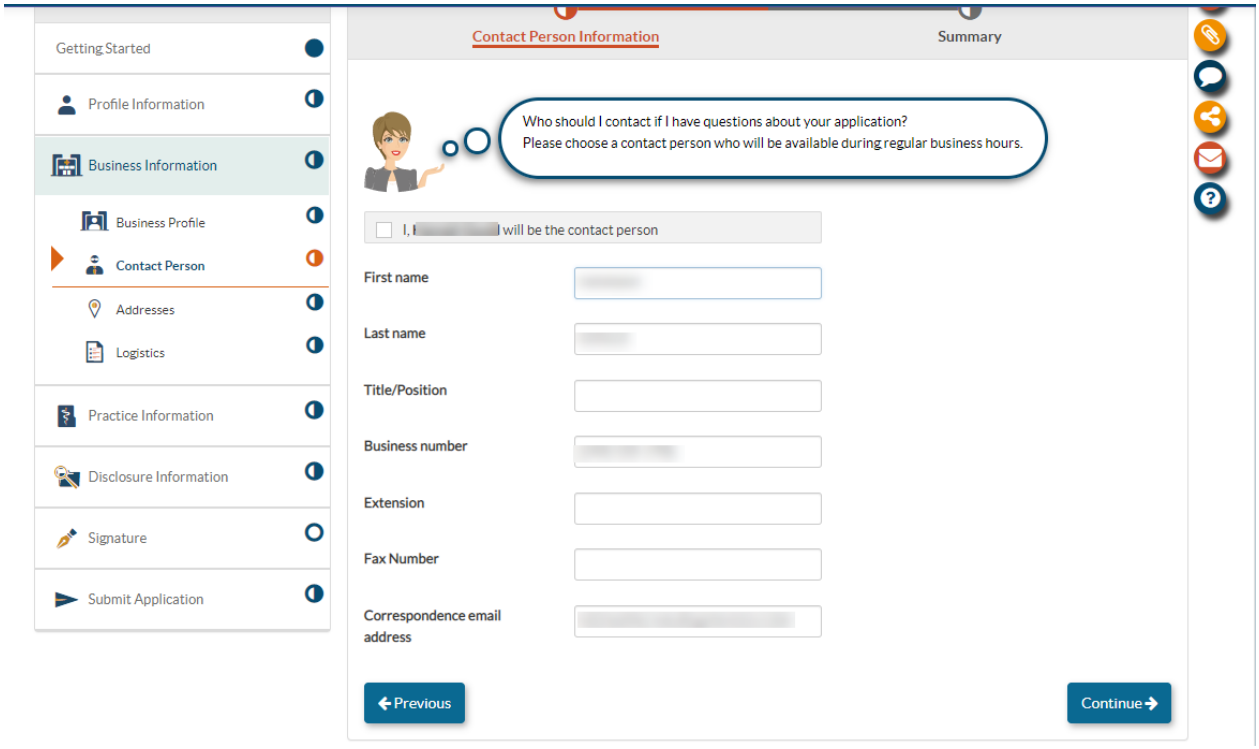


Please enter your SSN into the corresponding data field. Additionally, all individuals who are enrolling with Maryland Medicaid are required to obtain and disclose their SDAT number. Please do not select “N/A” as the application will be returned to you to provide this information.

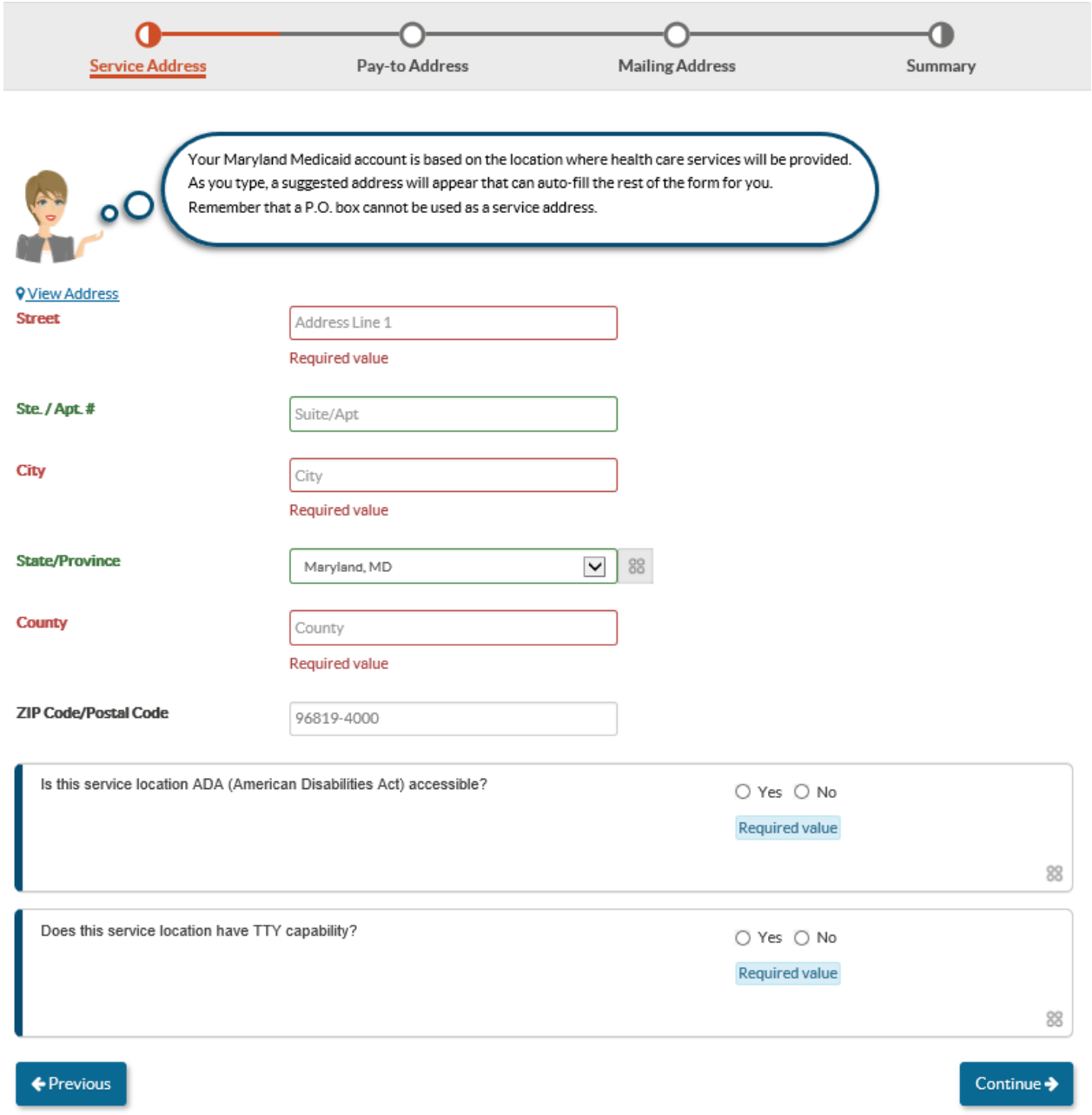
Should you have a DBA name, please select “Yes”, and attach the supporting documentation. If you do not have a DBA, please select “No” and click continue.



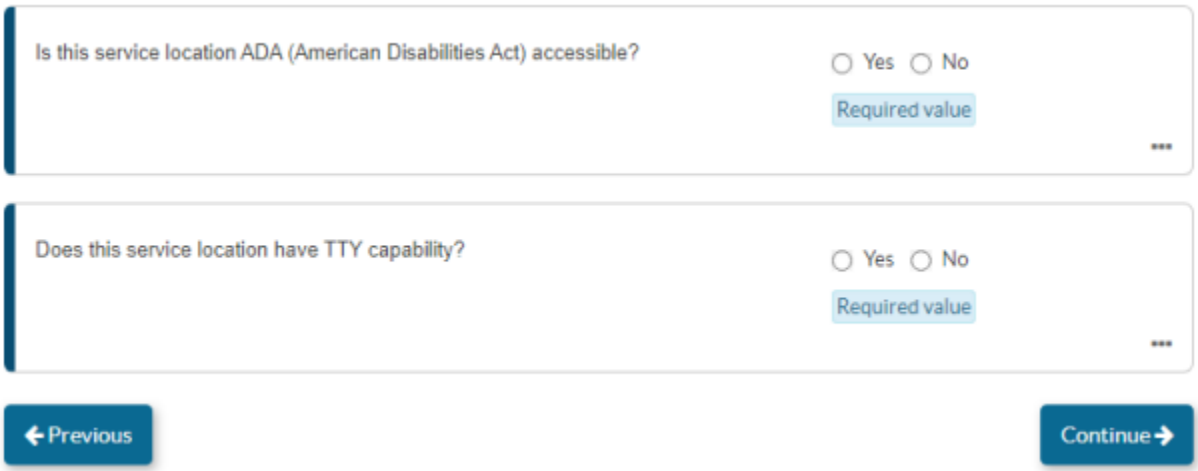
18. **Contact Person Information**: Please be sure to fill out the contact information correctly. The contact person should be the managing employee of the application. If there are any questions regarding the application, this person will be the direct contact person.



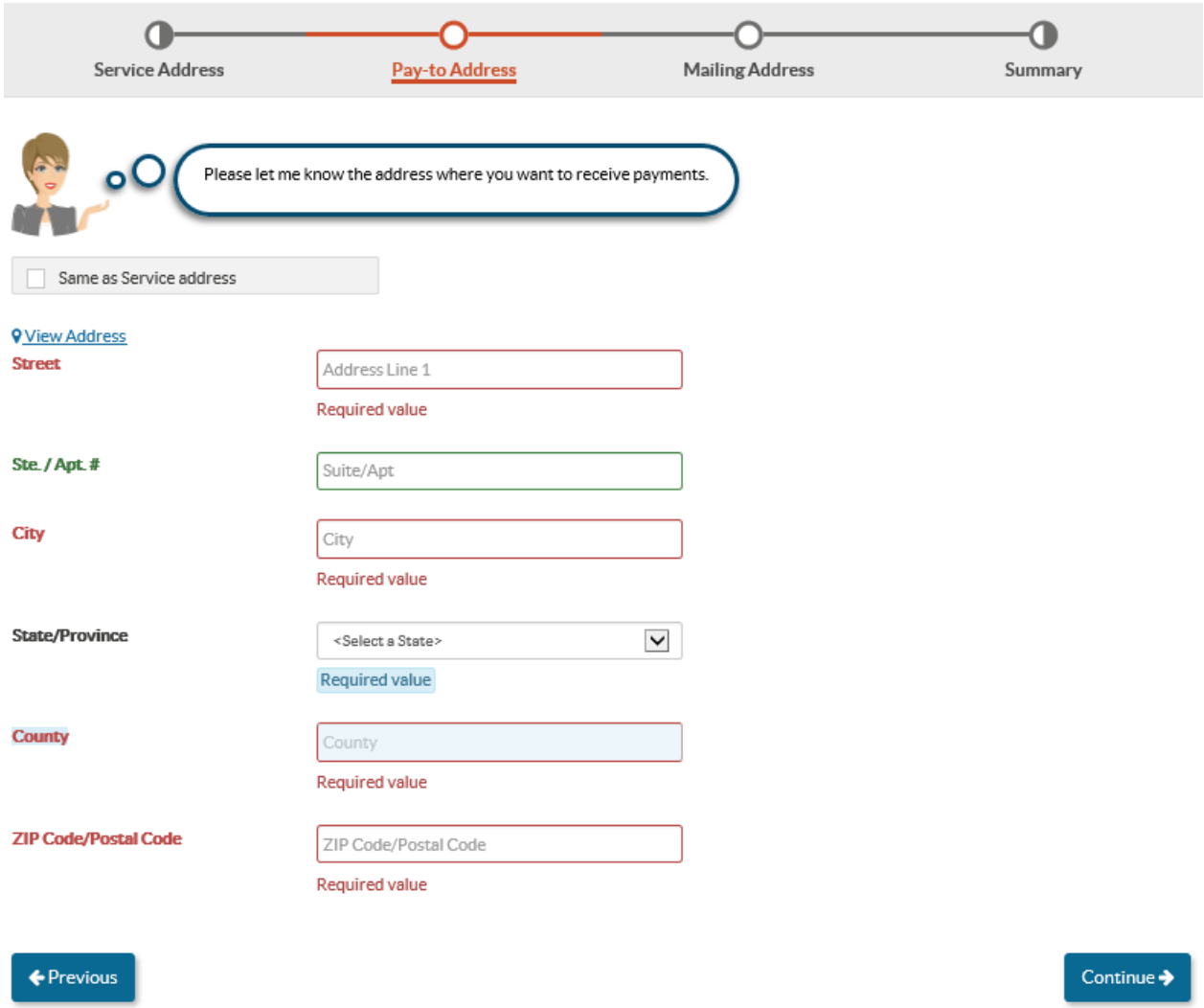
19. Please fill out the service address portion of the application:



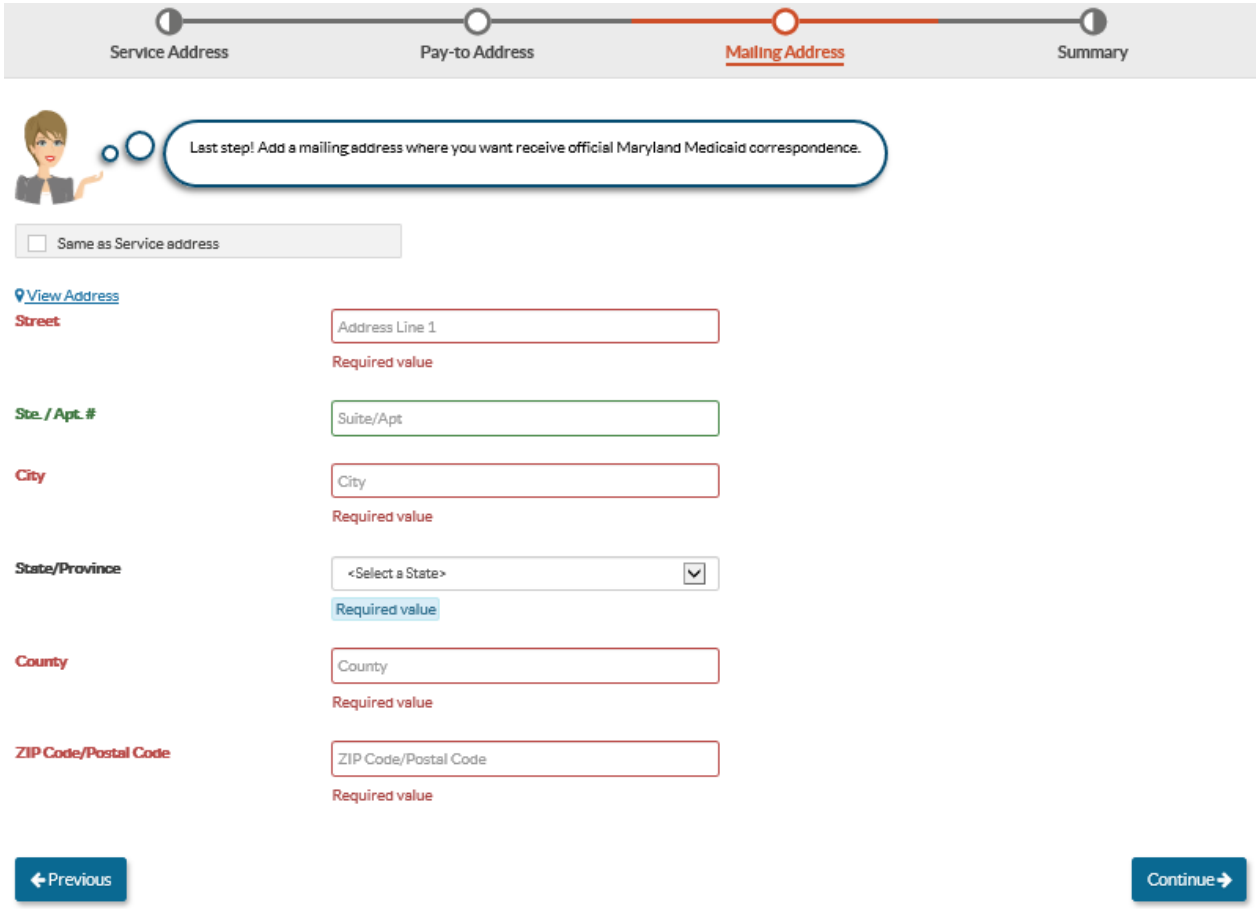
20. Please answer the following ‘Yes’ or ‘No’ questions:



21. Please fill out the Pay to Address of the location. (If you are not registered for EFT, this is the address the payment will be sent to.)



22. Please fill out the Mailing Address for the location. If there is a specific person that needs correspondence, please identify them. Please say: **ATTN:LAST NAME, FIRST NAME**



23. **Logistics**: Please answer the following 'Yes' or 'No' questions:

24. What are the business hours for this business location?
    a. If you are open 24/7, please check the box.
        b. If you are a business that has specific hours of operation, please list them here.

25. Has the individual listed on this application completed cultural competency training? Please answer 'Yes' or 'No'.

Has completed a cultural competence training?

○ Yes ○ No

Required value

26. Is the individual accepting new patients? Please answer ‘Yes’ or ‘No’ as it pertains to your business.

Is accepting new patients?

○ Yes ○ No

Required value

27. What is the age range of the patients that will be treated at this service location?

What is the age range of the patients that will be treated at this service location?

○ Enter age range ○ All ages

Required value

28. Does the individual see fee-for-services (FFS) Medicaid participants?
Please answer ‘Yes’ or ‘No’ as it pertains to your organization.

Does see fee-for-service (FFS) Medicaid participants?

○ Yes

○ No, I only accept HealthChoice managed care patients

Required value

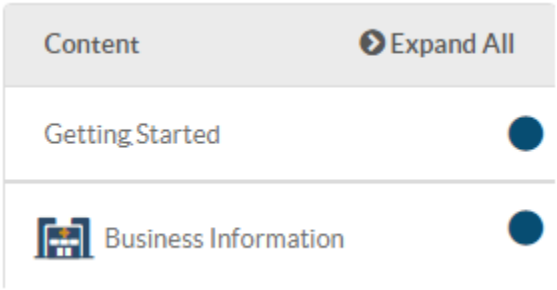
29. Does the individual provide language services to their patients, other than English, at this location? If “Yes,” please list all other languages in this section.

Does provide language services to their patients, other than English, at this location?

○ Yes ○ No

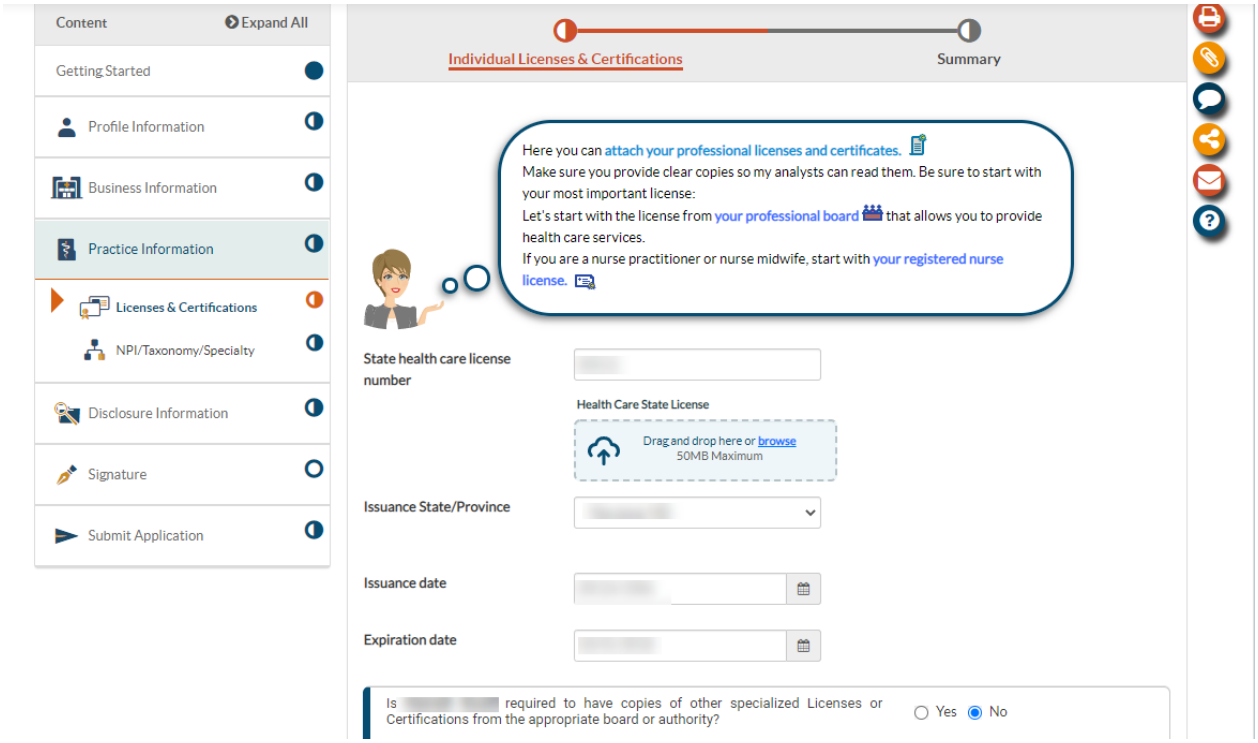
Required value

30. Once you have completed filling out all of the Business Information, the circle will be completely filled in.



31. **Practice Information Section**:

Please disclose all applicable licenses and certifications in this section of the application:



Examples of acceptable Doula Certifications:

CHILDBIRTH INTERNATIONAL
training without boundaries

This is to certify that

Student Name

has completed a course of instruction
and met the requirements for

Birth Doula Certification

and is now entitled to use the letters

CBD (CBI)

Graduate ID: XXX-######

Signed on this day dd Month YYYY

ACCREDITED PROVIDER WITH DISTINCTION
AMERICAN NURSES CREDENTIALING CENTER

Nikki Macfarlane
Founder & Managing Director
Childbirth International

CHILDBIRTH INTERNATIONAL
training without boundaries

This is to certify that

Student Name

has completed a course of instruction and met the requirements for

Postpartum Doula Certification

and is now entitled to use the letters

CBD (CBI)

Graduate ID: XXX-######

Signed on this day dd Month YYYY

ACCREDITED PROVIDER WITH DISTINCTION
AMERICAN NURSES CREDENTIALING CENTER

Nikki Macfarlane
Founder & Managing Director
Childbirth International

DONA INTERNATIONAL

35 E. Wacker Drive, Suite 850
Chicago, IL 60601-2106 USA
www.DONA.org

Be It Hereby Known That

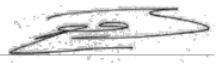
#1111

Certified Birth Doula

has successfully completed the Birth Doula Certification Program of DONA International, is permitted to use credentials CD(DONA), and is thereby qualified to offer professional labor support, following DONA International Standards of Practice, to birthing families.

Certification is contingent on continuous membership in DONA International.

3/31/2024
Expiration



Director of Certification

DONA INTERNATIONAL

35 E. Wacker Drive, Suite 850
Chicago, IL 60601-2106 USA
www.DONA.org

Be It Hereby Known That

#1111

Certified Postpartum Doula

has successfully completed the Postpartum Doula Certification Program of DONA International, is permitted to use credentials PCD(DONA), and is thereby qualified to offer professional postpartum support, following DONA International Standards of Practice, to families with newborn babies.

Certification is contingent on continuous membership in DONA International.

3/31/2024
Expiration

Director of Certification

Doula Trainings International

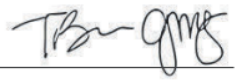
Jane Doe, CD (DTI)

certified full-spectrum doula

dti

September 28 2021

date



founders

THE
International
Black Doula Institute

CERTIFICATE OF ATTENDANCE

This temporary certificate is awarded to

as proof that the above has completed the 12 hour course and has earned the credentials as a

CERTIFIED PREGNANCY & CHILDBIRTH DOULA(BDI)

BDI#2021-60

Given on this 25th day of April, 2021 at the International Black Doula Institute

Nikita Johnson SM. COBST. CDBAD..

NIKITA JOHNSON
CEO/Director, BDI

April 25, 2023

Certificate Expiration

ICEA

The International Childbirth Education Association

hereby certifies that

Name, ICPD

has satisfactorily completed the requirements of the

ICEA Postpartum Doula Certification Program

and maintains the title of

ICEA Certified Postpartum Doula

2 January 2020
Date

31 January 2023
Expiration Date

Jenna Westheimer
Certification Program Coordinator

ICEA

The International Childbirth Education Association

hereby certifies that

Name, ICBD

has satisfactorily completed the requirements of the

ICEA Birth Doula Certification Program

and maintains the title of

ICEA Certified Birth Doula

2 January 2020
Date

31 January 2023
Expiration Date

Jenna Westheimer
Certification Program Coordinator

Mamatoto Village, Inc.
Certificate of Completion

recognizes that

_____

has successfully completed the requirements to be certified as a

Community Birth Worker

The program awarded the following credits: 45.0 contact hours

_____ _____

Date

Aza Nedhari, LM, CPM, MS,
Executive Director

Mamatoto Village, Inc.

Certificate of Attendance

recognizes that

_____

has successfully completed the following educational session:

Perinatal Health Worker Training

The program awarded the following credits: 192.0 contact hours

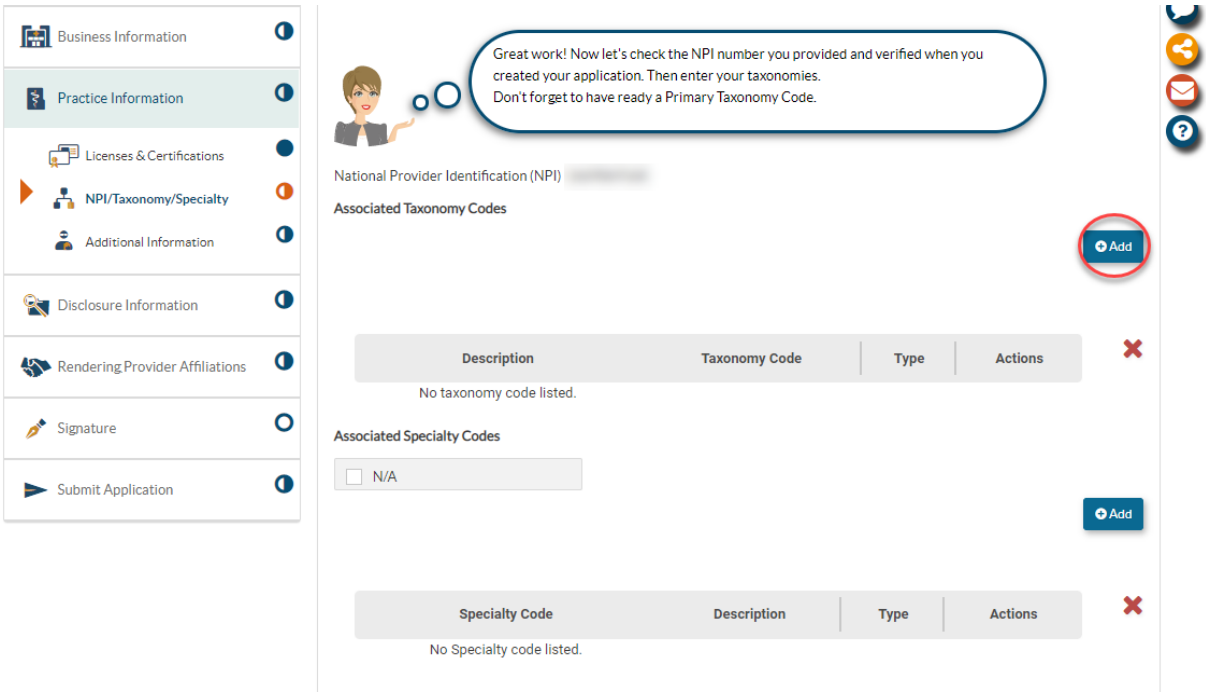
_____ _____

Date

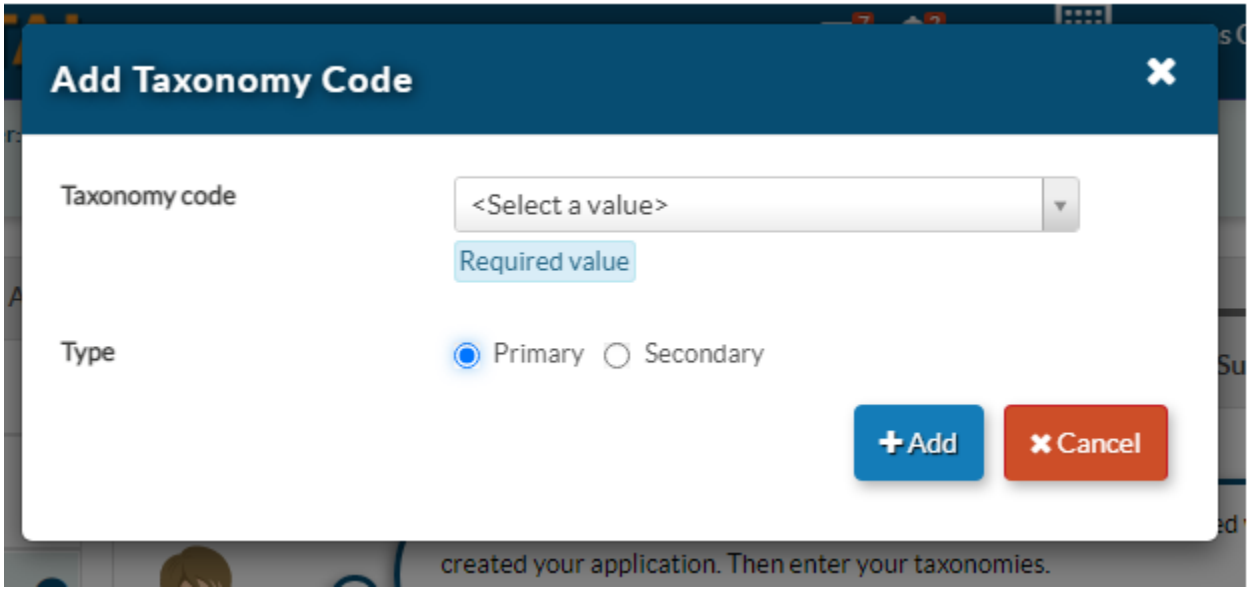
Aza Nedhari, LM, CPM, MS,
Executive Director

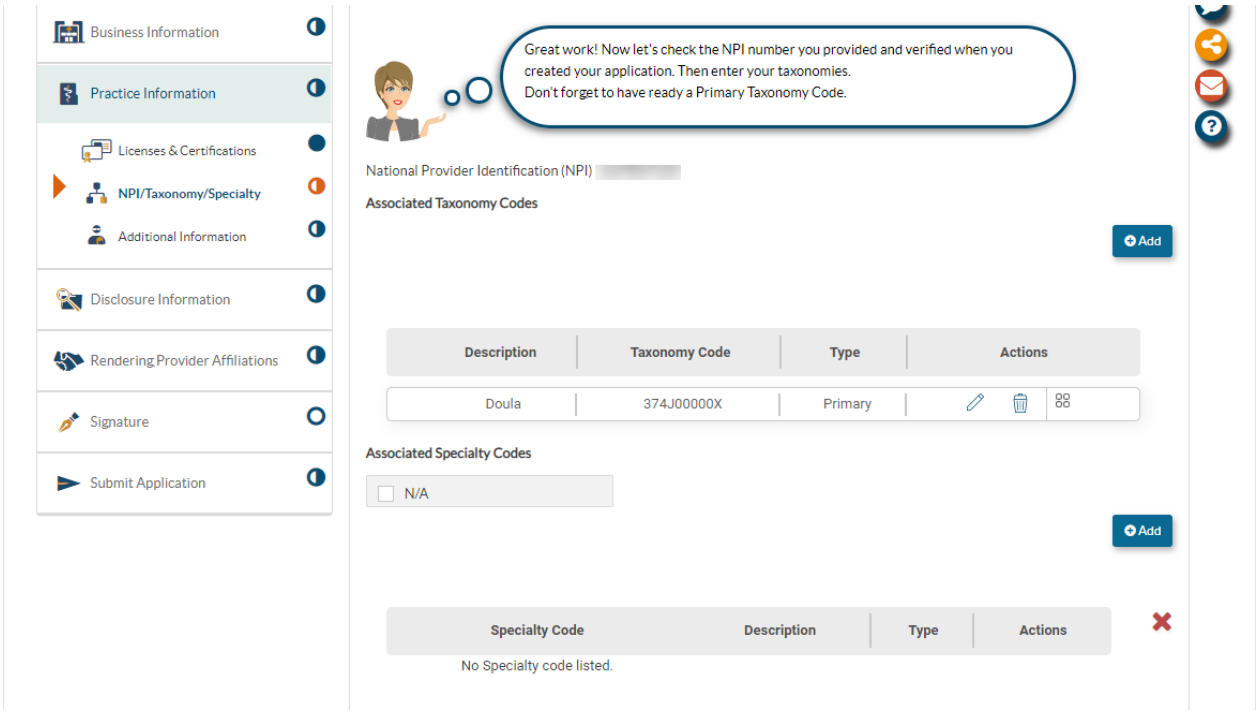
32. **NPI/ Taxonomy/ Specialty**: Please double check that the NPI listed on this page is correct.

a.The Taxonomy code should match what is in NPPES
b. If the individual has any additional specialty codes, please list them here.

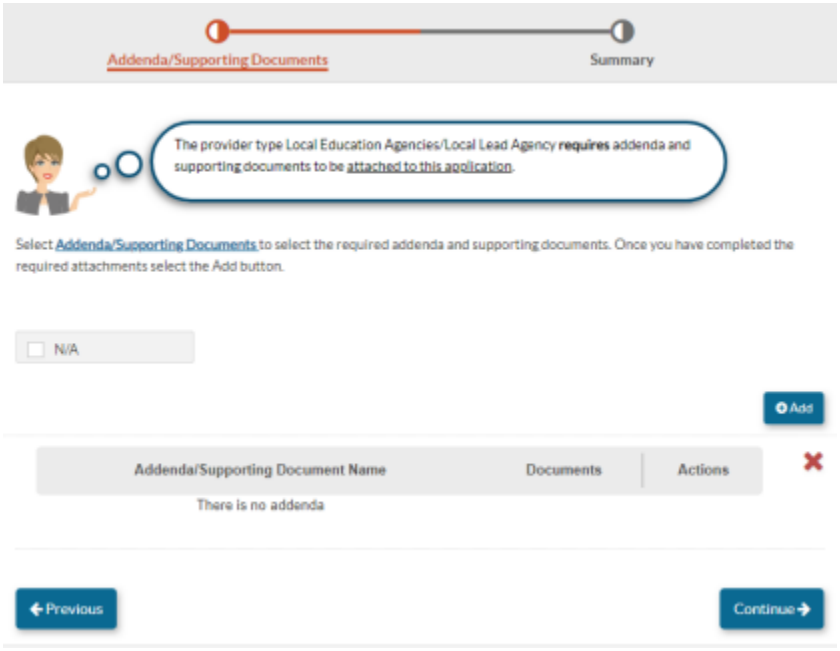


33. Please list the associated taxonomy code. This taxonomy code is listed in NPPES and was given to you when you first registered for the NPI.





34. **Addenda/ Supporting Documents** - Please be sure to attach the Medical Assistance Program Application. **Provider Type DL** - **Doula** is the correct addenda needing to be attached to this section of the application.



You can find the needed Addendum by going to the Maryland Medicaid website or by clicking on the following link and downloading the Addendum:

https://health.maryland.gov/mmcp/Pages/Provider-Enrollment.aspx

Addendum Example:

MARYLAND
Department of Health

Addendum for Maryland Medical Assistance Program Application PROVIDER

Doula/Birth worker - PT DL

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **7am – 7pm.**

All providers are required to use the electronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Individual Doula Attestation Form. Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Date of Attestation Submission: __/__/____

Attestation of Certification [Check the applicable organization, making sure that you have every certification listed for that organization.]

- ❑ Ancient Song Doula Services
  - o Full Spectrum Labor & Postpartum Certification
- ❑ Childbirth International (CBI)
  - o Birth Doula Certification
  - o Postpartum Doula Certifications
- ❑ The Childbirth and Postpartum Professional Association (CAPPA):
  - o Certified Labor Doula
  - o Certified Postpartum Doula
  - o Certified Community Lactation Educator Certification
- ❑ Doulas of North America (DONA)
  - o Birth Doula Certification
  - o Postpartum Doula Certification
- ❑ Doula Trainings International:
  - o Full Spectrum Doula Certification
  - o OR (Birth Doula Certification and Postpartum Doula Certification)
- ❑ The International Black Doula Institute (IBDI):
  - o Pregnancy & Childbirth Doula Certification,
  - o Postpartum & Newborn Certification
  - o Lactation/Breastfeeding Certificate of Completion
- ❑ International Childbirth Education Association (ICEA)
  - o Birth Doula Certification
  - o Postpartum Doula Certification
- ❑ Mamatoto Village
  - o Community Birth Worker Certification
- ❑ MaternityWise:
  - o Labor Doula Certification
  - o Postpartum Doula Certification

Attestation of Doula Program Certification [Check all that apply]

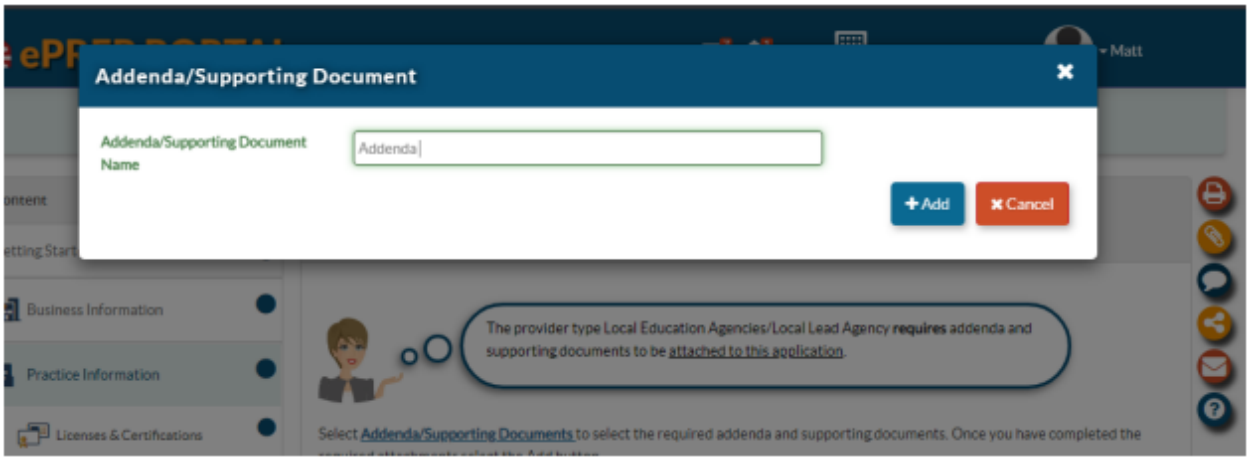
- ❑ The **individual** attests that they have obtained the certification checked above, and has attached documentation from the certifying organization.
- ❑ The individual attests that they will notify Maryland Department of Health (MDH) of any change in certification status within 30 days.

Attestation of Liability Insurance [Check one]

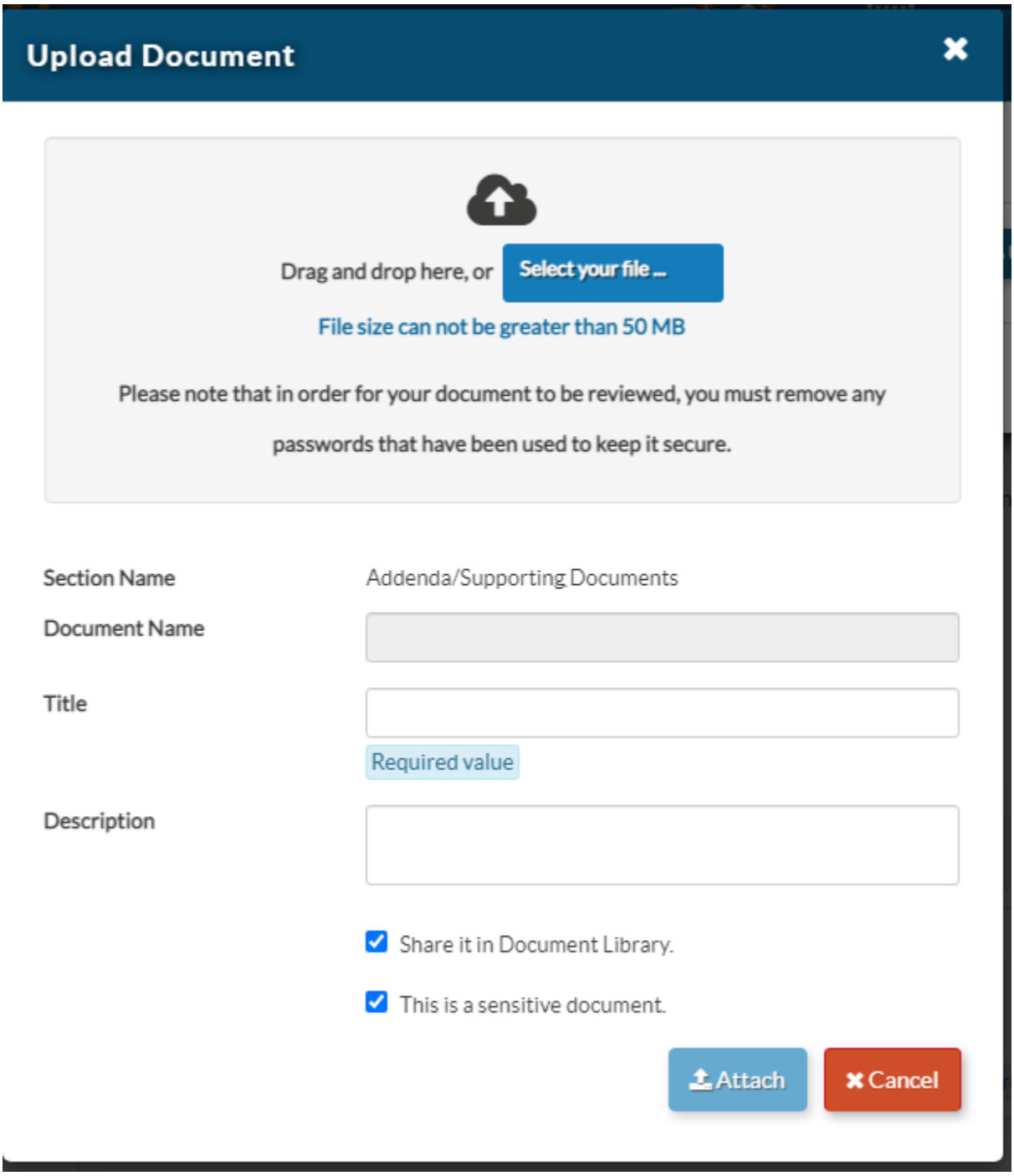
- ❑ Yes, I have adequate liability insurance.
- ❑ No. If no, please attach explanation.

Attestation of Fingerprint Criminal Background Check Completion

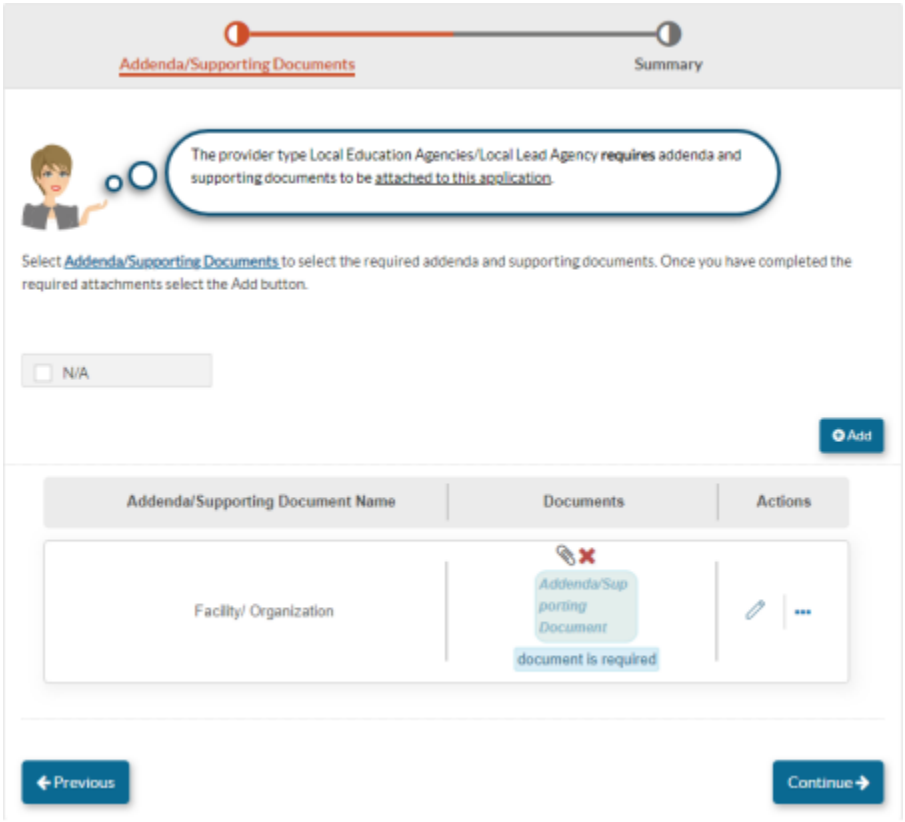
- ❑ I understand that all doula providers have passed a Fingerprint Criminal Background Check (FCBC).



35. Please click on the ‘Add’ button to name the Addendum.

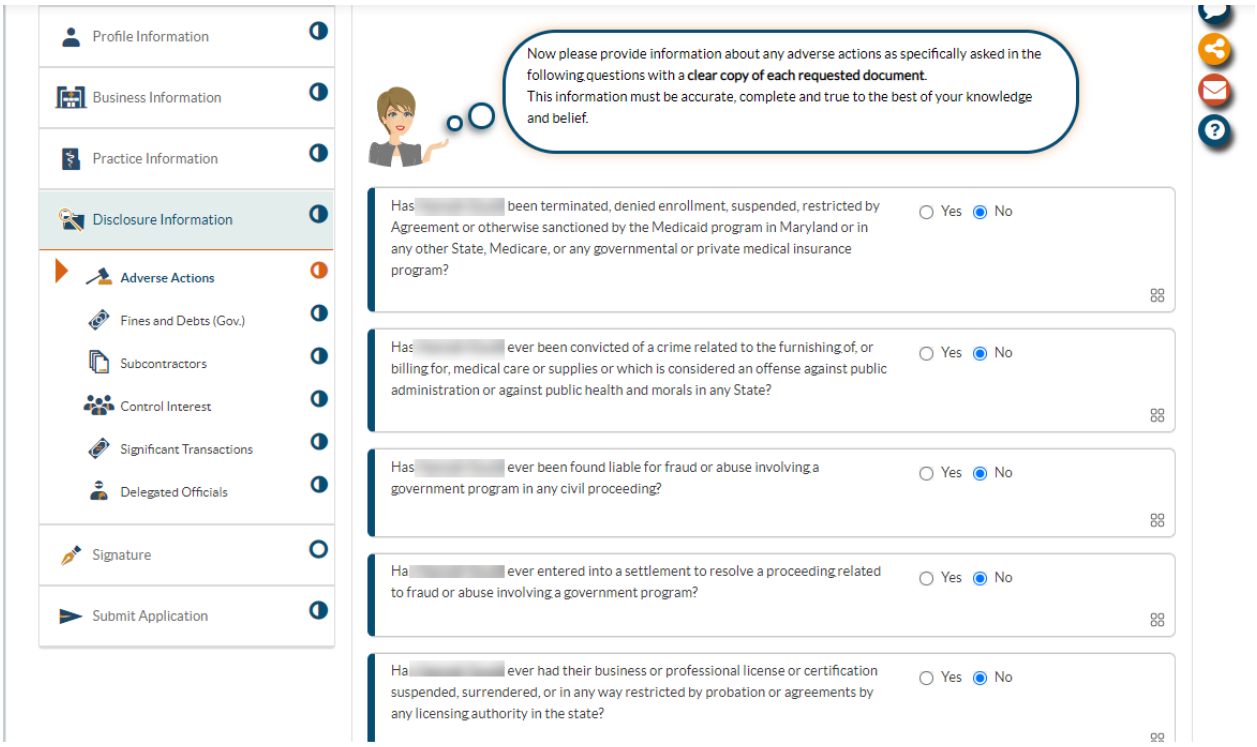


36. Please click ‘Add’ again to upload the Addendum.

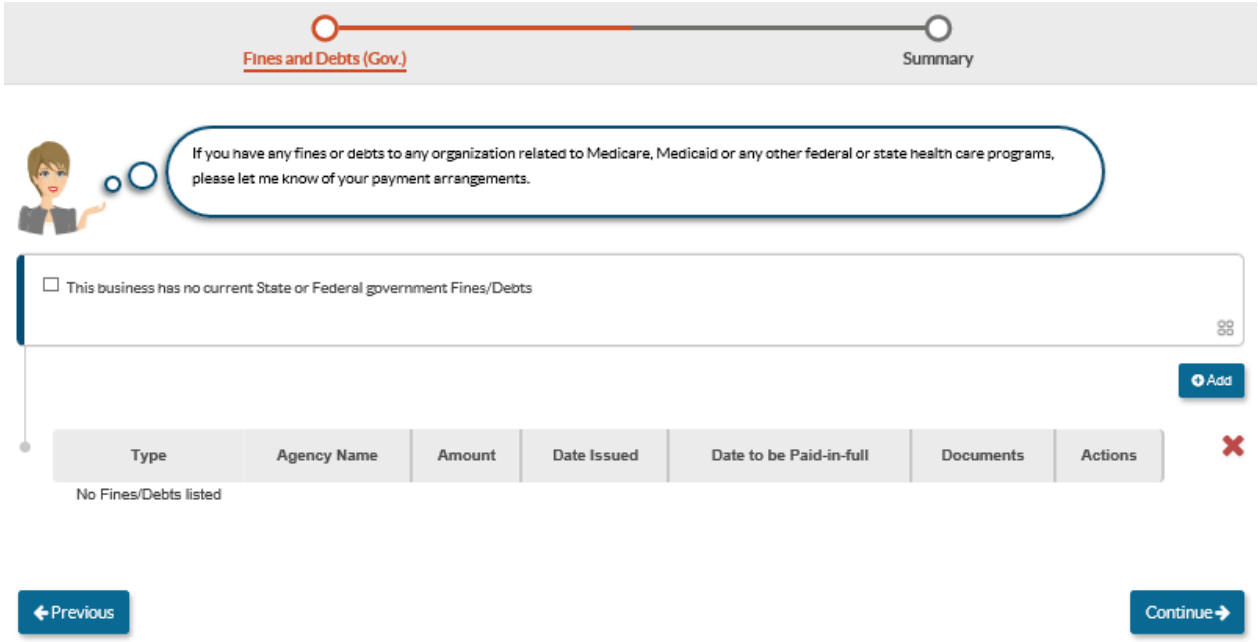


37. Once the Addendum is uploaded, please click continue.

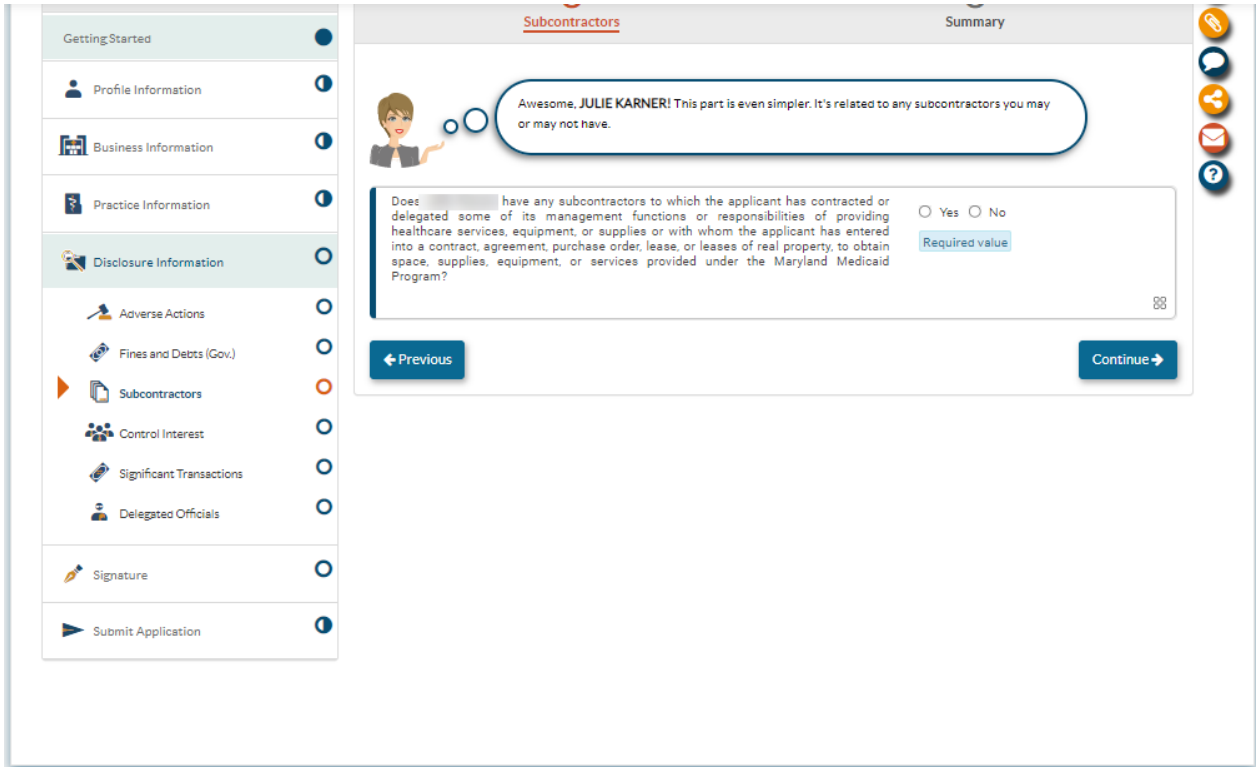
38. **Adverse Action**: Please fill out any adverse action information.



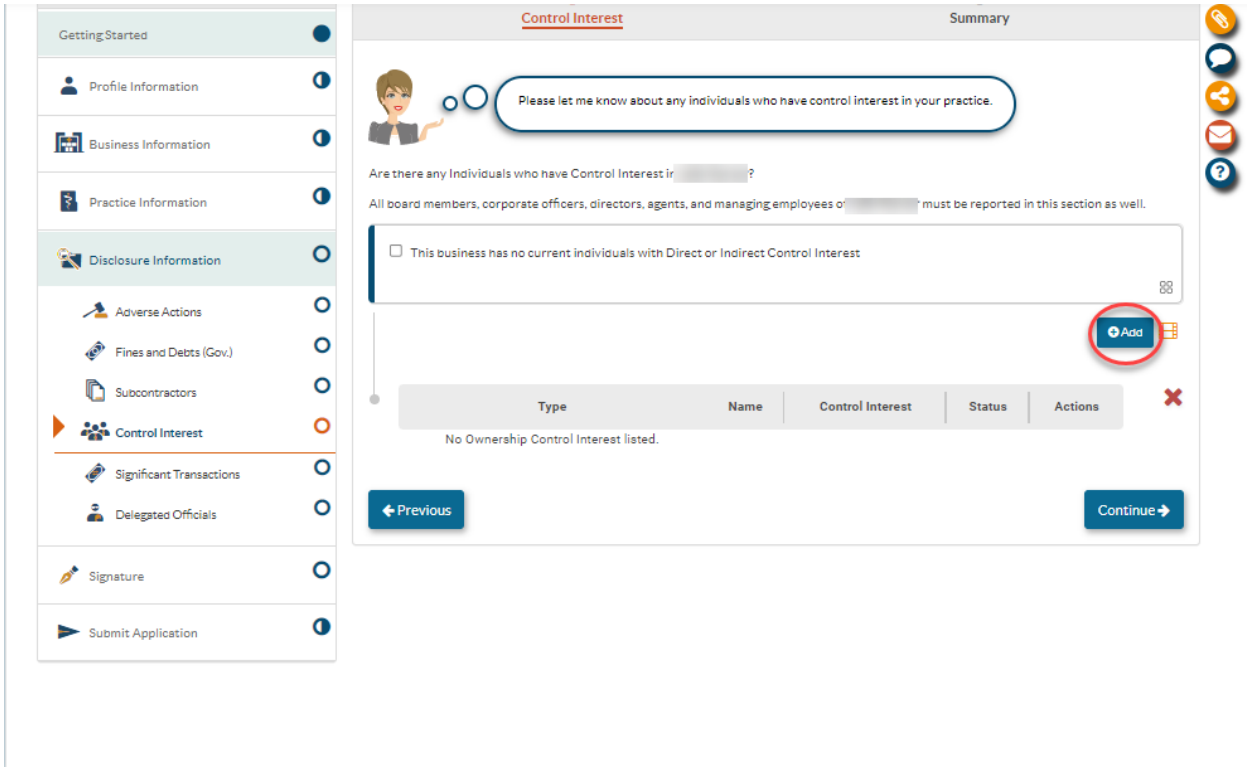
39. Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has. If the organization has none, please check the box shown in the screenshot below:



40. If you are a Solo practitioner, please answer the following questions as they pertain to your organization; If you are a rendering provider, this section will not populate on your application

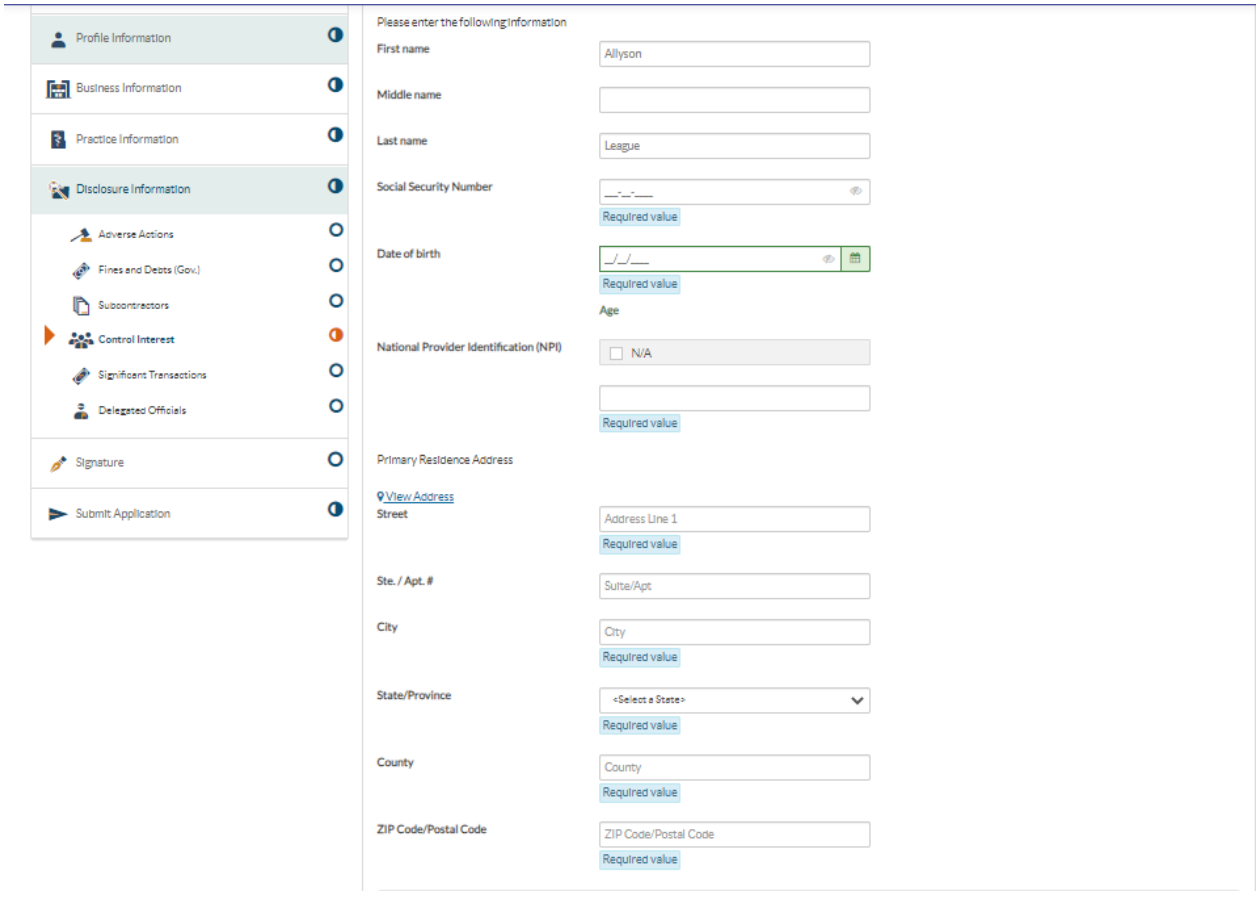


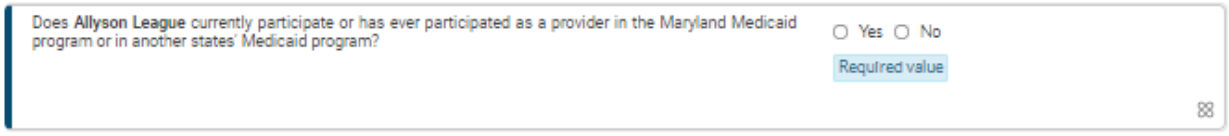
41. This is the Ownership/ Control Interest page. Should your organization have a controlled interest component, please click ‘Add.’



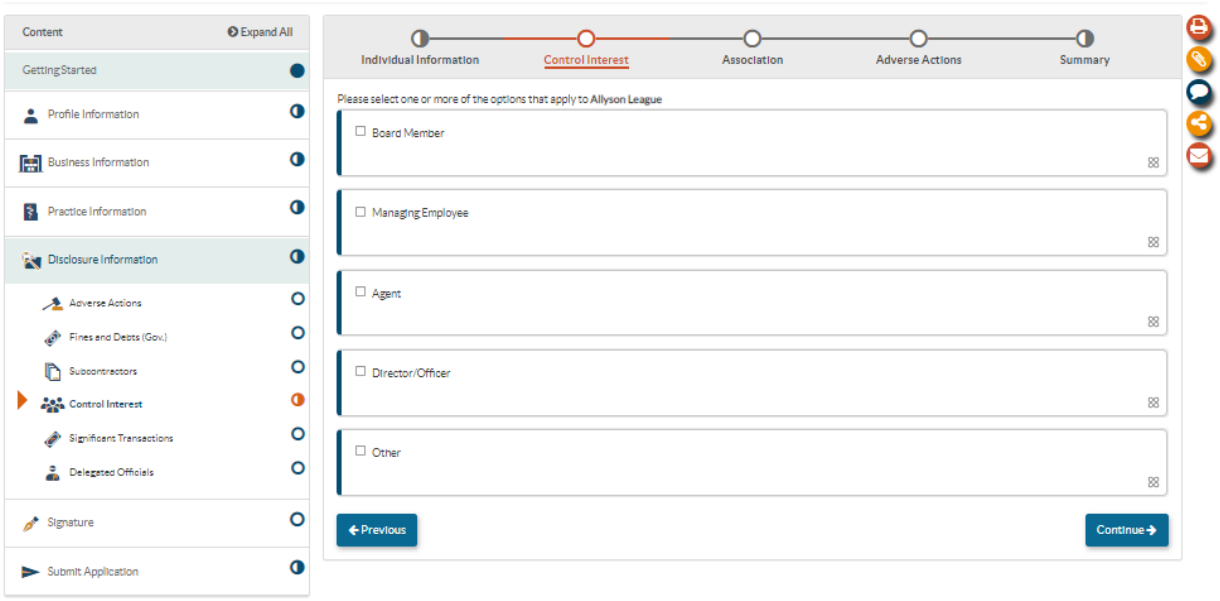
41. Please identify if the organization is owned by an entity or an individual.

42. With either the entity or individual, please identify their name.

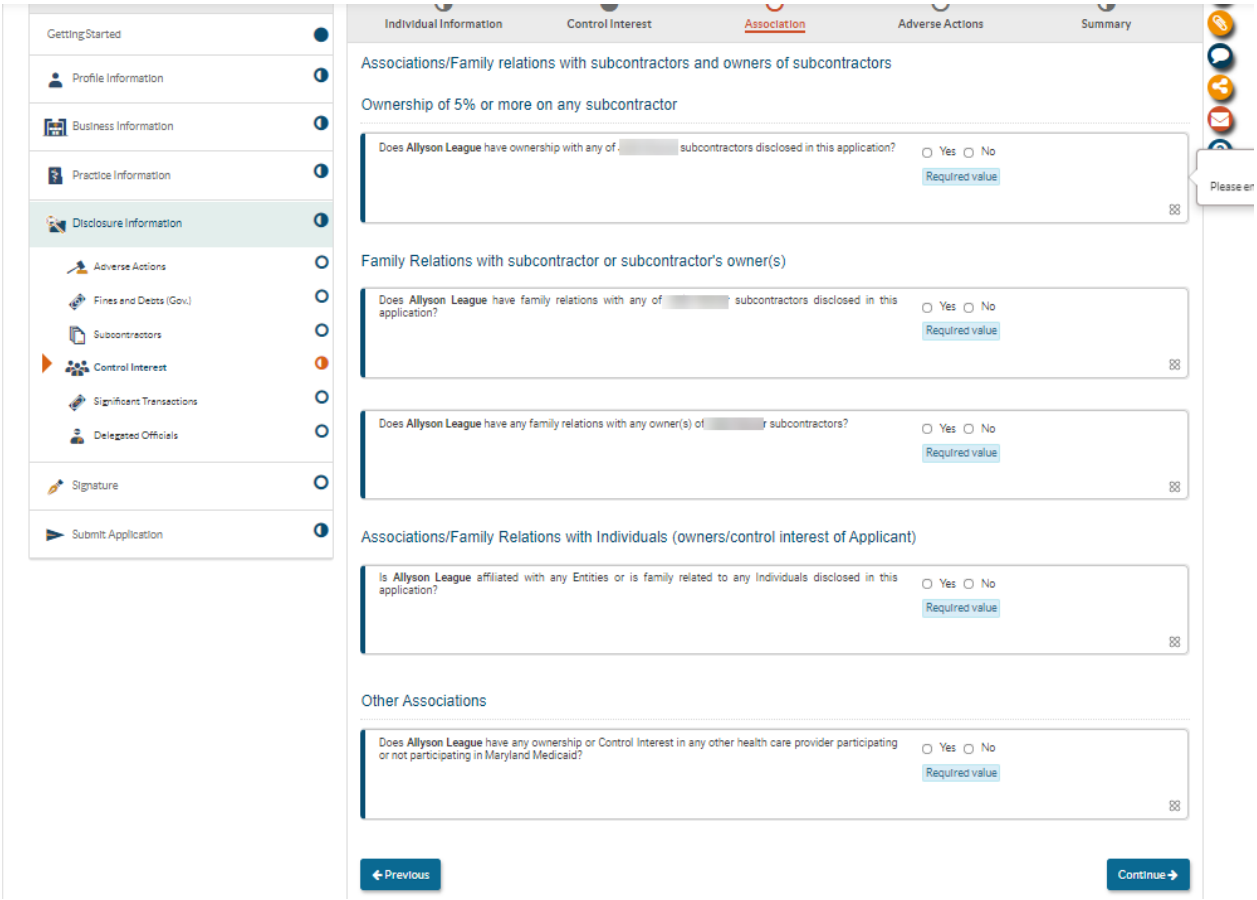




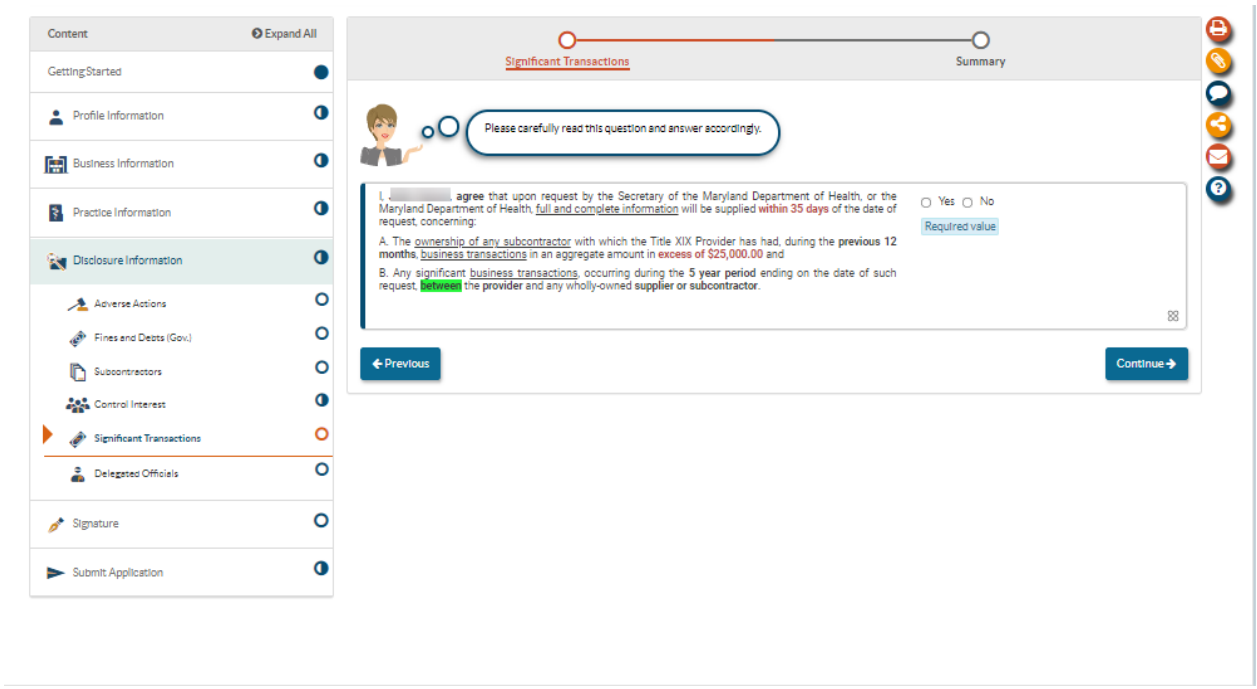
43. Please select the appropriate choice for the individual listed in controlled interest of the application:

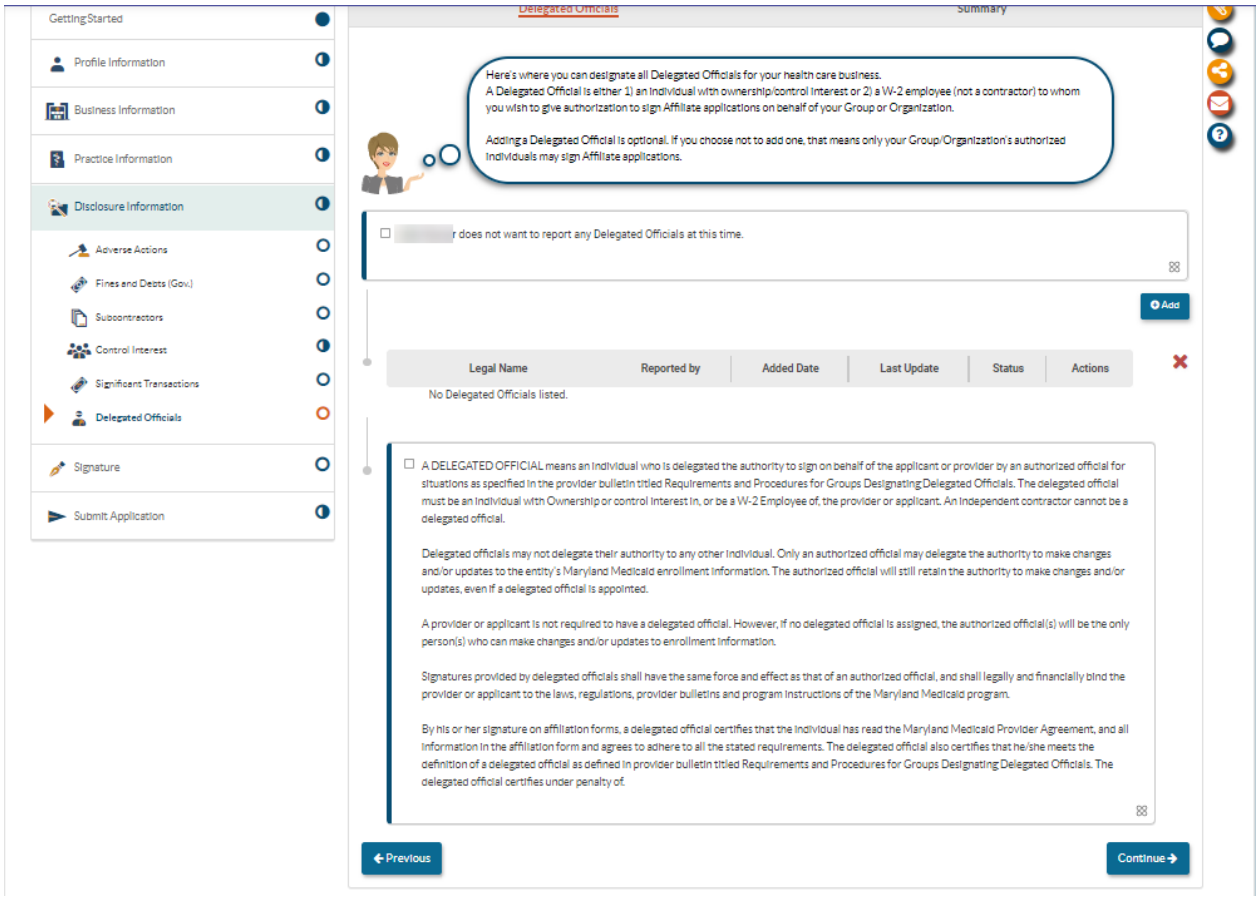


44. Please answer ‘Yes’ or ‘No’ to the following questions about the ownership entity or individual.



45. This is the ‘Significant Transactions’ page. Please mark ‘yes’ to the following question.


Content
Expand All
Getting Started
Profile Information
Business Information
Practice Information
Disclosure Information
Adverse Actions
Fines and Debts (Gov.)
Subcontractors
Control Interest
Significant Transactions
Delegated Officials
Signature
Submit Application
Significant Transactions
Summary
Please carefully read this question and answer accordingly.
I [redacted] agree that upon request by the Secretary of the Maryland Department of Health, or the Maryland Department of Health, full and complete information will be supplied within 35 days of the date of request, concerning:
A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000.00 and
B. Any significant business transactions, occurring during the 5 year period ending on the date of such request, between the provider and any wholly-owned supplier or subcontractor.
Yes
No
Required value
Previous
Continue

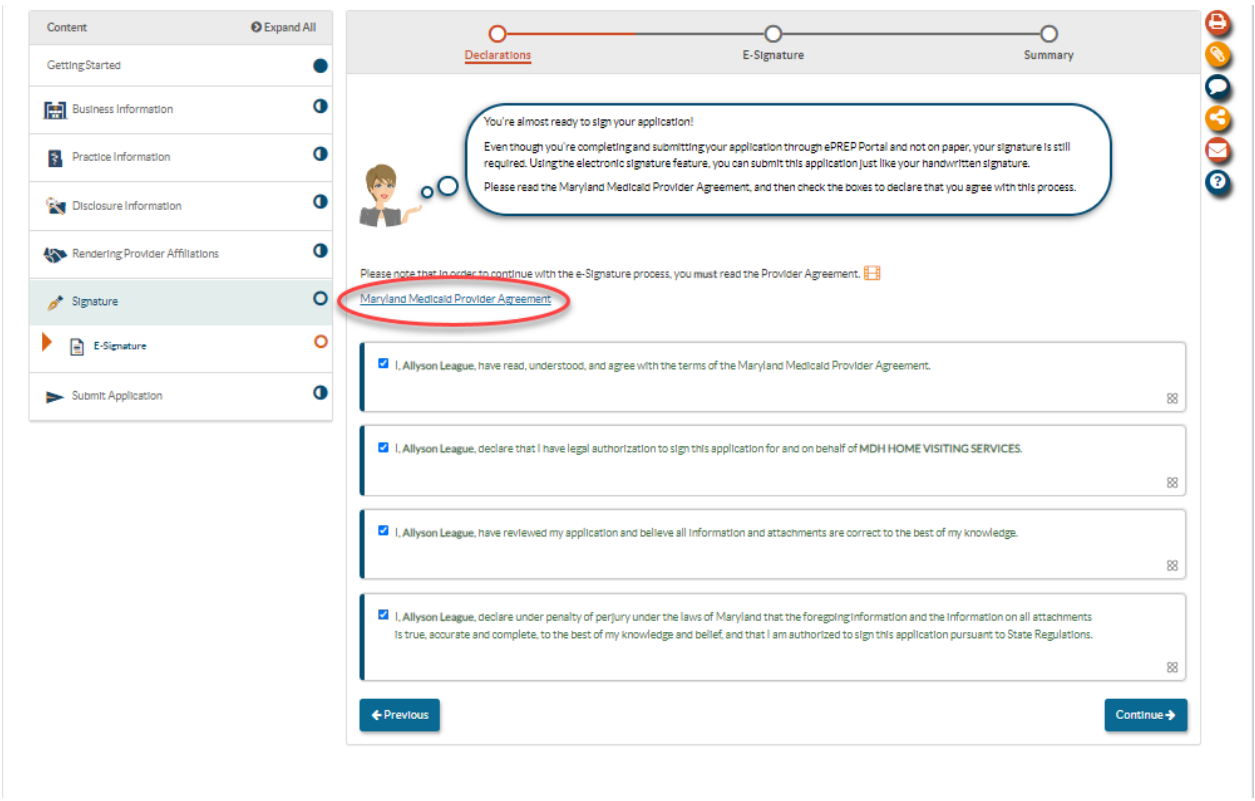


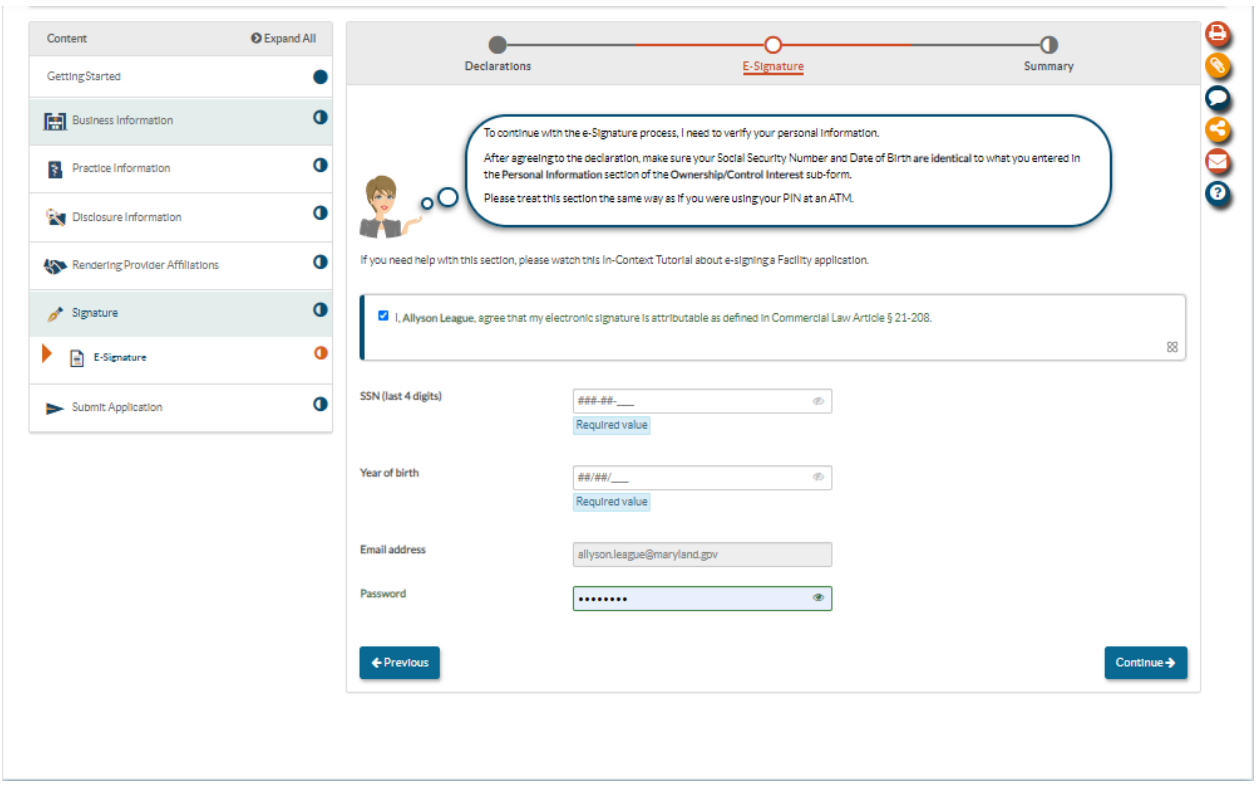
46. Please identify any delegated officials.

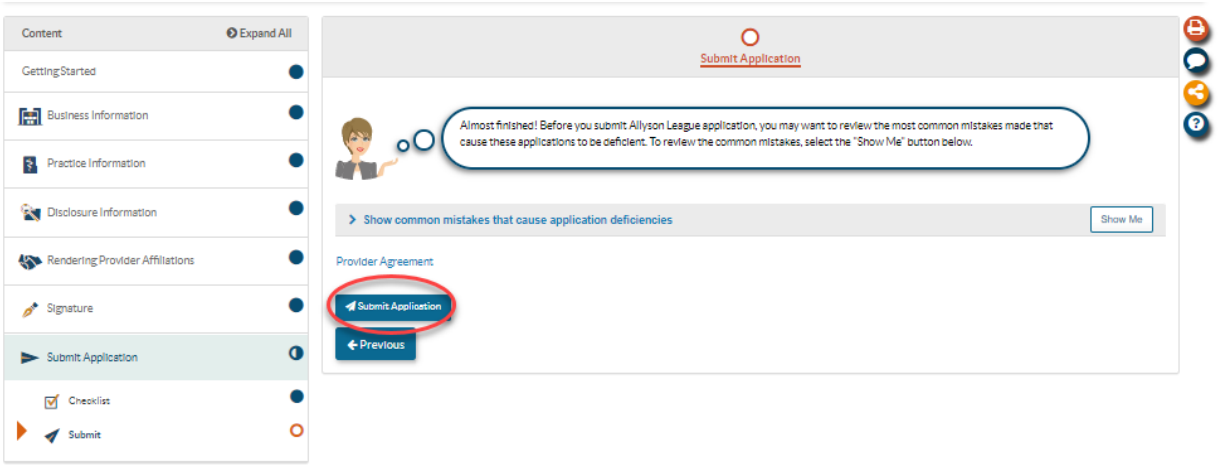
47. If there are no organizational affiliations, please click ‘No.’

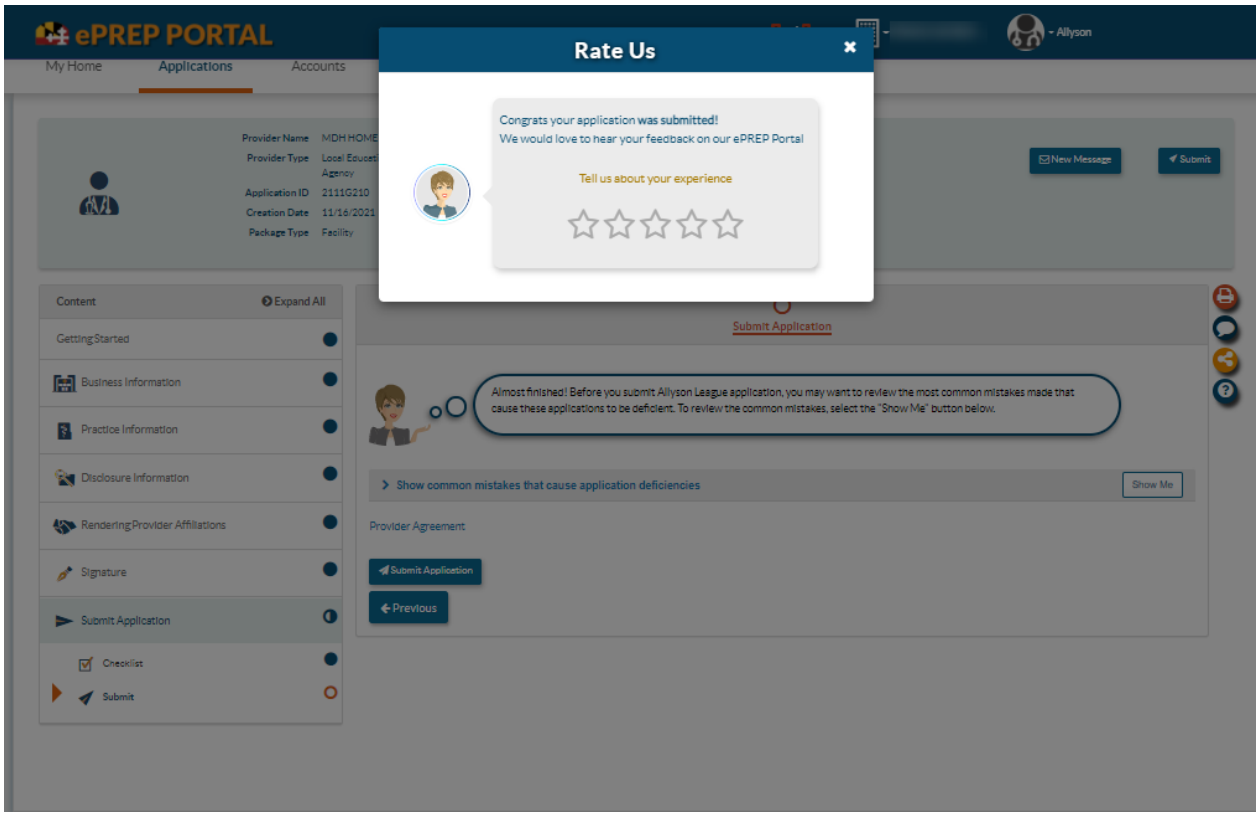
48. If the organization does have affiliations, please click ‘Yes’ and add any needed information.

50. Once onto the signature portion, please fill out the required information and click submit.


Content
Expand All
Getting Started
Business Information
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
E-Signature
Submit Application
Declarations
E-Signature
Summary
You're almost ready to sign your application!
Even though you're completing and submitting your application through ePREP Portal and not on paper, your signature is still required. Using the electronic signature feature, you can submit this application just like your handwritten signature.
Please read the Maryland Medicaid Provider Agreement, and then check the boxes to declare that you agree with this process.
Please note that in order to continue with the e-Signature process, you must read the Provider Agreement.
Maryland Medicaid Provider Agreement
I, Allyson League, have read, understood, and agree with the terms of the Maryland Medicaid Provider Agreement.
I, Allyson League, declare that I have legal authorization to sign this application for and on behalf of MDH HOME VISITING SERVICES.
I, Allyson League, have reviewed my application and believe all information and attachments are correct to the best of my knowledge.
I, Allyson League, declare under penalty of perjury under the laws of Maryland that the foregoing information and the information on all attachments is true, accurate and complete, to the best of my knowledge and belief, and that I am authorized to sign this application pursuant to State Regulations.
Previous
Continue


Content
Expand All
Getting Started
Business Information
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
E-Signature
Submit Application
Declarations
E-Signature
Summary
To continue with the e-Signature process, I need to verify your personal information.
After agreeing to the declaration, make sure your Social Security Number and Date of Birth are identical to what you entered in the Personal Information section of the Ownership/Control Interest sub-form.
Please treat this section the same way as if you were using your PIN at an ATM.
If you need help with this section, please watch this In-Context Tutorial about e-signing a Facility application.
I, Allyson League, agree that my electronic signature is attributable as defined in Commercial Law Article § 21-208.
SSN (last 4 digits)
###-##-____
Required value
Year of birth
##/##/____
Required value
Email address
allyson.league@maryland.gov
Password
Previous
Continue





Please feel free to rate the ePREP system and leave any comments that pertain to your application submission.

Thank you for your time.

If you have any questions, please contact us at

mdh.providerenrollment@maryland.gov